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“How could this happen to me?”

Young women’s experiences of unintended pregnancies: A qualitative study

Lesley Hoggart, Victoria Louise Newton, Louise Bury



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Acronyms

COC	Combined Oral Contraceptive	LARC	Long Acting Reversible Contraception
EC	Emergency contraception	MSI	Marie Stopes International
EHC	Emergency Hormonal Contraception	NHS	National Health Service
IUC	Intra Uterine Contraception	PMT	Pre-menstrual Tension
IUD	Intra Uterine Device	POP	Progestogen Only pill
IUS	Intra Uterine System		

Table of contents

Introduction	2
Research objectives and methodology	3
Table 1: Summary of all participants	4
Research findings	5
1. Most recent abortion	5
1.1 Becoming pregnant	5
1.2 Emergency contraception	7
1.3 Abortion decision making	10
1.4 Abortion pathway	10
1.5 Abortion experience	13
2. Post-abortion contraception	16
2.1 From user-dependent to long-acting methods of contraception	16
2.2 Preferring user-dependent methods	18
2.3 'Nothing works for me'	19
2.4 Contraceptive shirfitng following abortion	20
2.5 Selecting post-abortion contraception at the abortion clinic	21
3. Multiple unintended pregnancies	22
3.1 'It won't happen again': behaviour change between and after unintended pregnancy	24
4. Longitudinal interviews: Contraceptive changes over time	25
4.1 Still using method given at MSI	25
4.2 Swapping methods	25
4.3 Stopping contraception	26
4.4 Continuation with previous method	26
4.5 Starting contraception at a later stage	27
5. Post-abortion emotions and stigma	27
Conclusions	30
Recommendations	32
References	35
Appendix 1: Anywoman	37

Introduction

In 2012, when this research study began, the total number of abortions in England and Wales was 185,122. This was 2.5% fewer than in 2011 (189,931) (DoH 2015). The latest government abortion statistics show that there was a total of 184,571 abortions in 2014. This is 0.4% less than in 2013 (185,311) (DoH 2015). The percentage of women undergoing an abortion who have had one or more previous abortions is increasing, with more than one in three abortions in the UK in 2014 (37%) being a subsequent episode, an increase from 34% in 2010 and 31% in 2002. Among women under 25 years, 27% in 2014 had a previous abortion, the same as the previous year.¹

These data are often presented as a cause for concern, and abortion prevention is often presented as a key driver for the maintenance and development of effective contraceptive services (IAG 2009). However, not enough is known about the complex barriers to more effective contraceptive use, particularly following an abortion.

Reasons why women (in general) have unintended pregnancies that end in abortion have been fairly well documented (Bury and Ngo 2009; Garg *et al* 2001; Williamson *et al* 2009; Ingham *et al* 2008; Rowlands 2010). Explanations for unintended pregnancy include non-use of contraception or failure of a contraceptive method, poor knowledge due to lack of sex education, difficulty accessing contraceptive services, cultural/religious opposition to contraception, fear or misconceptions about contraceptive methods, and/or relationship changes (Bury and Ngo 2009; Rowlands 2007). However, as stated by Rowlands (2007), the idea that increasing access to contraceptive information and services that only target women so that they can use contraception more effectively, is too simplistic a view. There may be many further inter-related factors that go beyond the need for improved contraceptive services that contribute towards unintended and unwanted pregnancies. These include: coerced sex, substance excess or abuse, mental health problems, peer pressure against the deferment of child bearing, as well as increased sexual activity. More could be learnt about how these factors relate to each other and if there are particular circumstances, including behavioural, social and service related factors, that are more associated with unprotected sexual activity than others. In addition, factors associated with why women who have an abortion may go on to have subsequent unintended pregnancies and abortions are less well understood.

Marie Stopes International (MSI) is one of the UK's leading reproductive health agencies and provider of abortion services. Given the lack of understanding regarding the complex interplay of factors that influence the incidence of successive episodes of abortion, MSI commissioned a mixed methods study to investigate different aspects of young women's experiences of one or more unintended pregnancy ending in abortion. This paper reports on the third component of the study: a longitudinal qualitative study. It draws on the qualitative results to increase understanding about young women's experiences of unintended pregnancy and to identify ways in which local sexual health strategies and services can support young women, helping them to improve their reproductive control and avoid further unintended pregnancies.

¹ The percentage of women having an abortion in 2014 who had one or more previous abortions varied by ethnic group: 34% of Asian women had previously had an abortion, compared with 48% of Black women, and 36.6% of White women (DoH 2015).

Research objectives and methodology

This qualitative study addressed the following four broad questions:

1. *Why do many young women who do not want to become pregnant struggle to exercise effective reproductive control?*
2. *What influences young women's abortion decision-making processes?*
3. *What influences young women's post-abortion sexual behaviour?*
4. *How can contraceptive and sexual health services help young women avoid one or more unintended pregnancy?*

Overall the aim was to increase our understanding of why young women become pregnant when they do not want to be, and why this might happen on more than one occasion.

The research questions are based on gaining a better understanding of what influences young women's sexual behaviour before, and following, an abortion. Interviews focused on: individual decision-making; sexual and contraceptive behaviour before and after their abortion[s]; the relationships between their perceptions of social and cultural attitudes towards abortion; and the influences of 'significant others' on their decisions and experiences. Our analysis sought explanations for sexual behaviour, and changes in sexual behaviour, over time; and contraceptive usage (and changes) over time. It also involved analysing the processes by which individuals understood their own decisions and behaviour. The study followed a cohort of 36 young women (aged 16-24) who had agreed to be interviewed following an abortion at one of MSI's main centres. The study was reviewed and received favourable ethical approval from an NHS Research Ethics Committee.

Potential participants were identified with the help of MSI clinic staff. They were asked, after they had made arrangements for their abortion, if they would like to take part in a research interview. The project was discussed with them and they were given an information sheet. If they expressed interest in taking part they were asked to consent to their contact details being passed to the researchers. The researchers then contacted the young women to ask them if they were willing to take part in the study. If they agreed an interview was arranged to take place at a convenient time and in a place where they felt comfortable, or over the telephone. Fieldwork was conducted from February 2013 to April 2014. Approximately 1 in 5 expressions of interest resulted in a completed interview. At the start of the research interview informed consent was obtained. The first semi-structured interview (T1) was conducted 2-6 weeks post abortion. The second interview (T2) took place approximately 5-8 months after the T1 interview. Consent was again confirmed before the second interview. The differences in time reflect the challenges of conducting longitudinal research. The longitudinal element of the research allowed for reflection and discussion of patterns of behaviour over time. It is possible that participating in the research project could, in itself, prompt or contribute towards behaviour change, by encouraging the young women to think about their sexual behaviour and their lives more generally. This possibility was explored with participants in the second interview. The interviewer also tailored the follow-up interviews for each respondent by adding specific questions to a common core topic guide. We retained approximately half of the participants interviewing 17 out of 36 for a second time.

Throughout the project, we utilised thematic and case-based analysis, independently, on an ongoing basis. The data were coded thematically using the data management software package NVivo. Alongside this process the transcripts were read and re-read thus retaining case level analysis. As a memory aide, profiles of each of the participants were also constructed. The main strengths of the analytical approach were: the analysis is grounded in the accounts of young women themselves; the case-based (including some longitudinal) analysis facilitates exploration of subjective self-presentation (that may change over time); the thorough undertaking of independent analyses enabled the researchers to deliberate over different interpretations of the data as well as consider the validity of the final analysis. In this report quotations are used to illustrate the themes identified during this process, rather than the views of individual women, unless otherwise stated. Aliases are also used to protect women's identity and confidentiality. The draft report was available for participants to review.

Summary of all participants

Pseudonym	Age	Number of abortions	Number of children
Ahla	22	1	0
Alex	19	1	0
Annette	22	1	0
Becky	24	1	2
Bianca	22	2	1
Britney	22	1	1
Carrie	22	2	1
Cassandra	19	1	0
Danika	21	1	0
Dee	20	1	0
Donna	19	1	0
Edie	23	1	0
Ellie	19	1	0
Fern	17	1	0
Gemma	23	3	0
Holly	21	2	2
Jacqui	21	1	1
Jane	20	1	0
Jennifer	22	2	0
Kara	24	2	0
Lara	21	1	1
Larissa	22	1	1
Leah	19	1	1
Lucy	19	1	0
Maddie	21	1	0
Marlie	23	1	0
MaryAnn	21	1	0
Megan	16	1	0
Natasha	24	2 ²	1
Paige	23	1	1
Phoebe	19	1	0
Roxanne	20	1	0
Saskia	22	1	0
Shelley	24	1	1
Tara	20	2	0
Toni	21	1	0
Total women: n=36			

² Natasha had decided to have a 2nd abortion and arranged her clinic visit, when she miscarried. She still attended the clinic and had a scan to ensure the miscarriage was complete.

Research findings

Overall, the young women's experiences are characterised by a diversity of situational and behavioural scenarios in which they experienced one or more unintended pregnancy. These findings echo those of the quantitative survey which found it difficult to identify a particular 'type' of young woman who is most 'at risk' of unintended pregnancy and abortion(s): 'There were no significant differences between the characteristics of women who have had a previous abortion and those having one for the first time' (Bury *et al* 2014: 35). As with the participants in the quantitative study³, most participants in the qualitative strand had been actively attempting to avoid pregnancy but had suffered a contraceptive failure for a range of reasons. Where multiple pregnancies had taken place, their contraceptive had often failed for different reasons each time. Some participants had not used contraception, and again this was for a range of reasons. This findings section begins by analysing data from across the whole sample on participants' pre-pregnancy experiences during their most recent unintentional pregnancy; a section on emergency contraception is included. We first look briefly at their abortion decision making, followed by a section on participants' abortion pathways which includes referral, initial consultation and the abortion itself. We then consider post-abortion behaviour, again across the entire sample. The findings section then finishes with findings from two sub-samples: young women who have experienced more than one unintended pregnancy and who have had a previous abortion; and those participants whom we interviewed twice.

1. Most recent abortion

1.1 Becoming pregnant

This section explores the situations in which the young women in our study became unintentionally pregnant. Although it is important to acknowledge the diversity of these circumstances, and range of factors contributing towards unintended pregnancy, there are some common threads and we have grouped these into three overarching themes: 'unimaginable pregnancy', 'unpredictable pregnancy' and 'predictable, but not predicted, pregnancy'. These are not simply descriptive themes, but themes that seek to go beyond observations such as 'contraceptive failure' or 'contraceptive non-use' in order to understand why this might have been the case. In this way, the qualitative research complements and enhances the findings of the quantitative study.

Unimaginable pregnancy: *I thought I couldn't get pregnant*

In these scenarios, the young women were not using contraception because they did not think that they were able to become pregnant for a number of different reasons, all of which centred on a misunderstanding of their fertility and/or likelihood of getting pregnant. Misunderstandings about being 'at risk' of pregnancy featured in participants' accounts and often these were based on their previous sexual experiences and behaviour. If they had previously had unprotected sex and had not become pregnant they drew conclusions about their invulnerability to pregnancy:

I thought that maybe I couldn't get pregnant, and I was planning to go to the doctors to have a check-up to see if there was anything wrong. But then I didn't get round to that in the end, and then by the off-chance I got pregnant, and that's why it was such a shock, because I thought, oh, I couldn't get pregnant, because I'd been so long without [contraception]. (MaryAnn)

A few participants described specific underlying medical issues which they understood could negatively affect their fertility. Saskia, for example, had experienced a previous ectopic pregnancy and had been told that she was not ovulating post-surgery. She interpreted this to mean that her chances of becoming

³ Out of all 430 women, 57% (n=245) reported to have used a method of contraception at the time of getting pregnant. The majority were using short term methods: 30.4% the pill and 22.8% were using condoms. (Bury *et al* 2014: 16).

pregnant were very low and so did not consider using contraception:

Basically after the surgery that I had [for an ectopic pregnancy], I didn't have a period at all. So I've been told I'm not ovulating. So I don't really see how I fell pregnant. Now obviously I wasn't using any contraception at the time ... I went to my GP and I said, "I'm not having any periods", they said it's most likely I've not started ovulating yet. (Saskia)

Unpredictable pregnancy: I don't know why I got pregnant

In this category the young women were using contraception, and did not understand fully why they became pregnant. Some said they were unaware that their contraception had failed and later speculated that a condom had split, or they had missed a pill, been unwell whilst on the pill (vomiting and diarrhoea) or taking antibiotics which interfered with their pill⁴. Dee, for example, could not recall missing her contraceptive pill: *'I think I might have missed a pill. I know I should remember but I don't remember. I think I must have missed a pill.'*

Others could recall the situation in which their contraception failed, or when they took a risk, but they had then tried to prevent pregnancy by accessing emergency hormonal contraception.

I think we'd slept together about 1am/2am in the morning and by the afternoon I was in the [Sexual Health] Centre having the pill [EHC]. I'm not quite sure why it didn't work. (Fern)

A common factor in this scenario of 'unpredictable pregnancy' was that the women had not anticipated the possibility that they might become pregnant. They did not understand why contraception – including in some cases, emergency contraception – had failed for them.

Predictable but not predicted pregnancy: I hoped it wouldn't happen to me

The participants in this scenario struggled to use contraception effectively for a number of reasons and engaging in 'unsafe' sex was acknowledged. In the main, an unintended pregnancy could have been predicted as a possible (foreseeable) risk. However, for a number of reasons it was not conceptualised as such. Alex, for example, clearly hoped that *'it's just not going to happen to me'*:

I think it was partly to do with because I was almost in disbelief that I would get pregnant So I just ran away from it and hoped for the best I guess I was worried but I was almost 'it's just not going to happen to me, it can't, it just can't happen' I had a slight bit of hope that the pill would still be in my system, not that I based that on any fact, just on me, and that was it really. (Alex)

Complex personal lives and relationships often had a significant role to play. Some participants had trouble assessing their 'need' for contraception because their sexual activity was not regular:

Because I think I'm at uni, like I don't see him that much, and so like, because I've been on the pill, it's sort of that urgency of taking it, it sounds really ridiculous, but it hasn't sort of seemed to be so urgent, because I'm not having sex all the time sort of thing, so I did miss a couple, which is probably why I ended up falling pregnant. (Toni)

Other participants had difficulty finding contraception they were happy with. Danika, for example, was frustrated by the undesirable side-effects she experienced whilst using hormonal contraception:

I just think drug-wise, there must be something other they can create that's not going to affect people

⁴There is a lack of evidence supporting a relationship between non-enzyme inducing antibiotics and reduced oral contraceptive efficacy. A cautious approach is usually adopted in the UK and traditional practice advises the use of additional precautions with short courses of antibiotics. However, it is now advised that additional precautions are not required for non-enzyme inducing antibiotics (FSRH 2012). Therefore it is likely that these young women's contraception failed for other reasons, however, they retained the information that antibiotics can affect the contraceptive pill (and some seem to have been suggested this explanation on presentation at their GP) and believed this to be an explanation for their unintended pregnancy. This is an indication that women were searching for reasons to explain what – to them – was inexplicable.

how it does. Because I've been through so many and they say, 'you have to go through them to find the right one,' but it shouldn't be like that, I don't want it to affect the whole of me. (Danika)

Sometimes participants had found it difficult to seek out contraception because of their busy lives and limited clinic opening hours. Younger women also faced access issues because they were less independent and felt less confident attending services. Megan, who was 16, told us: *'whereas I always wanted to get it [the pill] before but just going to like a clinic or something just seemed really weird, like I wouldn't be comfortable doing it.'*

1.2 Emergency contraception

In the quantitative survey Emergency Hormonal Contraception (EHC) prevalence was 12% among the sample (13% for those who did not use contraception, and 11% for those who used contraception but were aware it had failed) (Bury *et al* 2014: 18). Many young women in the qualitative study could recall the situation in which their contraception failed, or when they took a risk with their contraception, particularly with unpredictable or unanticipated sex. After engaging in unprotected sex, some had sought out EHC, others had not.

Why and when EHC is not used

It was evident that although some participants were aware that they were at risk of pregnancy they did not seek out any form of emergency contraception. This finding supports the quantitative report which found that a high proportion of women (87%) who did not use contraception at the time of pregnancy did not seek to use EHC. This would be expected from a sample of women who had experienced an abortion, and it is useful to consider why this was the case. Approximately one third (31.1%) of these did not know, or said there was no reason why they did not use it. Another third (31.1% believed they could not get pregnant, 29.5% said they 'did not think' to take EHC and a smaller proportion of women (6.8%) said that it was difficult to access EHC (Bury *et al* 2014: 18). Participants in the qualitative study gave a number of reasons for not accessing EHC. In particular, accessibility, cost, and a lack of accurate knowledge about the method, were the main barriers. MaryAnn describes her experience:

I didn't know where was open, I think it was a Sunday and I didn't know what was open and I think I was busy that day and also I don't know how many times you can have the emergency one, 24 hours after, yes, I didn't know how many times you could have that when you've already had it once; I had years and years ago. Yes, that reason, and I didn't know if it cost anything. Some of my friends have said that when they had it previously they had to pay for it and I didn't know how much that would be.

Worries about the cost of EHC also seemed to discourage other participants. Megan, a younger participant at 16, said she could not justify spending money on something if she was not absolutely sure she needed it. In this case she felt she needed to know that her risk of pregnancy was 'definite'. Since she underestimated the risk of getting pregnant she decided not to access EHC.

I had friends who had like some of them have got it for free and then others have had to pay like £30, £40. And I don't know, I mean, I'm only 16 and I wasn't going to, it's kind of weird because it's hard, like if you've got to pay out like £30, I mean, I have a part time job but it's still a lot to just pay I mean, I always thought that if I had to pay out that money, then I wanted to know that it was definite.

These experiences and decision-making processes were not uncommon. Megan may have benefitted from a better understanding about how EHC works and when in her cycle she was most at risk of getting pregnant. She would also have benefitted from a greater awareness about where she could access free EHC.

Other reasons for not accessing EHC were timing related and often also involved women hoping for the best. Some participants noted that they had thought about seeking emergency contraception, but that they

had left it too late: *'I did think about it afterwards but by the time I'd really thought about it was too late, we were past that, I think the 72 hour mark'* (Ahla). In some cases participants were on holiday, away from home, and unfamiliar with their surroundings and services: *'we were away [on holiday] so we got back and I was like, okay, I think we should go and sort this out, but it was too late to get the morning after pill and things. So yeah, but it's just one of those things really.'* (Danika)

There was awareness among participants that EHC is more effective the sooner it is taken after unprotected sex. However, it was often not taken immediately, despite widespread knowledge that it becomes less effective with time. Delays were for similar reasons to the ones participants gave for not taking EHC – often they could not get to the chemist or clinic any sooner. Participants also expressed some generalised concerns about EHC with some describing a perceived stigma associated with using it 'too often':

I already feel myself that that's four times that is too many, because I just hear – especially in this area as well – like people use it as contraception, not emergency contraception, because people can go to the doctor's and ... So a doctor will write it out for them, they don't have to pay for it, and it's like I think people just really take advantage of it to be honest. (Natasha)

The notion of using EHC 'too often' also fed into 'myths' about the method. Maddie told us: *'The more you take it the less effective it is'*. This idea was fortified by concerns about how EHC might affect or harm their bodies: Natasha also said *'I thought that the emergency contraception was not good for your body'*. This was echoed by other participants:

I feel like I'm hesitant to use it, I feel it might reduce my chances of being able to have a baby in the long run I think I might have heard it from a few friends saying that when they had gone to get it they were told you shouldn't really take it too often, it's not the contraceptive pill, it can make you have a chance of it affecting you. (Alex)

When EHC fails

For all the participants who sought EHC to try and prevent their most recent pregnancy, it had obviously failed (as it had for 12% of the quantitative sample).

Fern was upset and felt let down by the education she had received about the medication: *'It was just like everything that you get taught at school, like, if you're in trouble you can go to a sexual health centre and you can take a tablet and then everything will be fine. It just felt like everything that you'd been taught, you'd been lied to.'* (Fern)

When she accessed EHC, Fern was asked how long it had been since she had unprotected sex, and also when her last period was. It is evident from the exchange below that sex may have taken place around ovulation when EHC is less effective (Glasier *et al* 2011):

Fern: *They just asked me how long it had been since I last had sex and when it had been and just when I'm next due my period and when my last period was They didn't offer me much advice, really because I was really worried at the time.*

Interviewer: *Yes. So they asked you when your last period was.*

Fern: *Yes, and they asked me when my next period would be as well.*

Interviewer: *Okay. And do you remember roughly whereabouts you were? How long it had been since you'd had a period?*

Fern: *I think it had only been about two to three weeks.*

Interviewer: *Okay. I know it's difficult to remember such a long while ago. And did they explain why they asked you when your period was?*

Fern: *No. They just said it's a protocol question, because you're period's meant to come, is it every four weeks? Roughly.*

Interviewer: *Yes.*

Fern: *Mine come roughly every four weeks.*

Interviewer: *Yes, that's right.*

Fern: *So depending on when my last period was, depending on whether I'd have to wait for my period to see if it came, or whether I should go back and have a pregnancy test.*

In Natasha's case, she was close to the 72 hour 'cut-off' point for the effectiveness of the method. She was not advised by the pharmacist that she could have an emergency IUD fitted elsewhere. Instead the advice centred on buying a pregnancy test to check later whether the EHC had worked for her.

Interviewer: *So were you worried straight away that you might be pregnant?*

Natasha: *Do you know, yes and no. I kind of thought – it was once, and I'd only just come off the pill and I thought 'Oh, maybe not'. And then a day and a half had passed and I thought 'Oh maybe I will go and get the morning after pill tomorrow, just to be on the safe side'. And then I did. I took the morning after pill, but it was really almost on the 72 hour mark.*

Interviewer: *When you went to get the morning after pill, did they offer you anything else, apart from the pill?*

Natasha: *No.*

Interviewer: *And where did you go to get it?*

Natasha: *[name of pharmacy].*

Interviewer: *Did they talk to you about how long it was since you had unprotected sex?*

Natasha: *They asked me the date, and they just said 'So you do realise that the longer you've left it, the less effective it is'. So I said 'Yeah'. And they said 'Take a pregnancy test in two or three weeks to be on the safe side'. And that was all, really, there was no advice, no leaflet.*

Natasha later blamed herself for her situation, having not taken EHC sooner: *'when I took the emergency contraception it was late so I'd only got myself to blame really. I do know that it loses its effectiveness the longer you leave it and I left it, so that is my fault.'* However, Natasha had underestimated her risk based on the hope that her oral contraceptive pill might still be in her body. She noted that if she had had an EHC supply at home she would have taken it 'straight away'. Natasha found out later that she could have had an emergency IUD fitted, which would have prevented her pregnancy. She felt quite aggrieved that not all her options for emergency contraception had been explained to her:

I guess you could be quite bitter about something like that because if you haven't got all your options, I mean I had the worst outcome I had to have a termination so if that could've been prevented there and then I probably would've gone through with [having an emergency IUD fitted] if that was offered to me.

Our findings on becoming pregnant have shown a range of different situations, different behaviours, and different beliefs that can contribute towards experiencing an unintended pregnancy. As this is a qualitative study we cannot speculate on the likely numbers of women experiencing any one situation, but we are able to suggest that these various scenarios are not unique. What stands out from this study is that – in the main – these young women are becoming unintentionally pregnant in situations that are not uncommon and that do not always result in pregnancy. But sometimes they do, and then women find themselves in a situation they had not anticipated with a decision to make about an unintended pregnancy.

1.3 Abortion decision making

Making the decision to have an abortion was not characterised by one common factor, but was for a broad range of reasons, with each woman considering their own situation and what would be best for them and their existing families and relationships. Participants spoke about their decision-making process which was considered: *'I spoke to my boyfriend about it, and we talked for like days and days, until we made our decision'*. (Jane)

Maddie also took time to make her decision, returning to the clinic a second time after feeling unsure in the first instance:

[I] took a while ... I'd been there once to think and I had to go home because I couldn't do it, and then I had another week ... I spoke to my family and I just come up with the decision that it would probably be best for me at the moment.

Life-stage considerations and financial hardship were common drivers in their decision-making. Participants considered their own wellbeing, the wellbeing of a future child, as well as that of any existing children. The younger women, often drawing on popular conceptions of 'good' motherhood which chimed with their own personal values around marriage and family, felt they would be unable to bring up a child because of economic disadvantage:

We both don't earn enough money obviously to keep a baby, a baby's a lot of money. We don't have a house to live at other than living at like mum and dad's or his mum and dad's so it's a bit like ... And then obviously I still wanted to work, he still wanted to work, but I think the only way we would've survived is if I gave up work and went on the social, and I didn't, I didn't want to do that. (Donna)

Notions of 'family life' and 'stability' were evident as was a desire not to bring a child into a 'less than ideal' home situation:

We wanted to get a mortgage, we want to get married and things, we wanted to do it the traditional route to be honest. I've only just been in my job for about four months, my partner has just started a new job so none of us were sort of in stable enough positions to financially bring up a child. (Marlie)

For some, the consideration of the welfare of existing children was an important factor.

If I had another mouth to feed, it would mean that her quality of life would drop and I know it probably sounds really horrible because that was a baby as well but she's here and now, and she's more important than anything. And the thought of her quality of life dropping, just upset me because I thought I've brought her into the world, I knew it wouldn't be easy but I'm doing all right, she's doing well, she's got everything she needs, she's got all the love that she needs. I can put food on the table. I didn't want to jeopardise it. (Larissa)

In general, the women were very concerned to present their decision to have an abortion as the responsible course of action for their own future lives, including future family lives. They were particularly keen to reject the possibility of unplanned motherhood for themselves.

1.4 Abortion pathway

This section focuses on the women's experiences of their abortion from referral onwards.

Referral experience

For most of the women, once they had decided to have an abortion the process progressed quite smoothly. Ahla was very clear in her decision and the steps she needed to take:

I went just to the pharmacy and got some pregnancy tests and then did them. It was very clear to me that, like, the next step is to go and get an abortion and book an appointment I think I went to the doctors on the Thursday and on the Friday I booked the appointment and it wasn't that Saturday but it was the following Saturday I had the termination. (Ahla)

A few participants, however, experienced considerable difficulties. For those women who experienced difficulties these were mainly due to location, but in some cases were related to difficulties experienced at General Practice level.

It was a nightmare trying to get it. I went to three clinics, and one said because it wasn't my borough anymore, so I went to [another one] and they were like, you need a doctor's written letter or something. So I went to the doctor, so I had to register with them then, and then I saw a doctor in there and he was like, 'Oh, I don't deal with that, religious views'. So I had to see another doctor He was like, 'There's another doctor here you can see'. And then he gave me the number for the Marie Stopes. So I just, I left there and I rang them, and they just arranged a phone conference thing that day. I went in the following Monday. (Carrie)

I went to the doctor's and I asked them to see if they can book me in for an abortion, and she tried to book me in, but when I phoned up to confirm the booking, they said they had no recognition of me on their [system], at all – so then I had to phone them and book it myself, then, and I had to wait another two weeks, and by the time I actually went for the abortion, I was already like three months. (Bianca)

In the accounts of Carrie and Bianca, the young women were not aware that they were able to self-refer for an abortion (though this is what Carrie had done after being given the phone number). Those who immediately went down the self-referral route found the process, in the main, reassuringly straightforward.

I rang at about nine o'clock on a Sunday evening. It is absolutely brilliant that they are open 24 hours. It wasn't a case of I had to wait until Monday morning or anything like that. I rang them about nine o'clock on Sunday night. The lady who picked up the phone, obviously asked me why I was ringing. I said, and they booked me an appointment for, I think it was two weeks, to go for a consultation. Like just to go for a consultation in the clinic, just to talk it through and have some tests done and everything. So at that point, I knew nothing was set in stone. So it was... I felt like I was making progress towards sorting out the situation but at the same time, I wasn't pressured into making that decision straight away. (Larissa)

Consultation experience at MSI

The first appointment that will be made for any woman enquiring about an abortion at MSI is for a consultation. This can be by telephone, or at one of the MSI clinics, depending on women's preferences. The purpose of the consultation is for women to discuss their situation; and to obtain information and advice about their abortion options. They are also asked about their current contraception. At this stage women who are considering an abortion are provided with information to help them to make an informed decision. There is a discussion on whether they want any counselling, which method of abortion they would prefer, and what their contraceptive requirements following the abortion might be. This discussion follows a set script. The quantitative report showed that high percentages of women were 'very satisfied' with their abortion consultation and services experience at MSI (Bury *et al* 2014: 34). This was largely echoed in our qualitative study: on the whole, women were happy about their consultation experience, though those who had selected a telephone consultation sometimes had difficulty recalling the details of the conversation.

Pre-abortion decision counselling, although available, was rarely accessed by participants, who were often sure of their decision before contacting MSI. Britney, for example, explains in the exchange below that she did not feel she needed counselling:

Britney: *They said that I can have a consultation on the phone if I wanted and I said no, I'd rather go in. They also said that I should be getting some counselling and they can offer and provide counselling. They just gave me an appointment sort of thing and that was it.*

Interviewer: *Okay. So they offered you counselling? Did you decide...*

Britney: *No.*

Interviewer: *No? Why was that?*

Britney: *I don't feel like I need it.*

Similarly, Paige told us: *'I didn't need it'*. This was not to suggest that access to pre-abortion (and post) counselling is not important, but it does suggest that women in the main are aware of whether or not they require further discussion or counselling. Annette did take up pre-abortion counselling, but felt that it was not helpful to her, although she valued the service being available:

I thought the counselling was an absolute waste of time, to be honest. It literally didn't do anything for me at all ... She just didn't really – she just ummed and ahed. I think it was more really for me to just get stuff off my chest, but then I could have done that speaking to my mum. So it's good for other people, but for me, it did nothing for me ... It's good that they offer that service though.

Other participants, such as Tara and Edie did need more support and they recognised this need. Tara was already engaged in mental health services and did not use the service provided by MSI. She did however feel that it was a positive thing to be offered: *'they were really good about it, offered me counselling beforehand, which I didn't take because I had a counsellor already'*.

In the exchange below, Edie describes her experience with pre-abortion counselling at MSI.

Interviewer: *Okay. So, was that counselling something that you decided to do, did you have to do that?*

Edie: *No, they offered it to me so I took it because they said... they called me for the consultation over the phone but they was like, 'You don't sound very sure'. So they said it's better to go and talk to someone and make sure I've made the right decision.*

Interviewer: *Okay, so tell me about that counselling session then, as much as you can.*

Edie: *They lady was really nice and that she talked sense into me but not being too pushy and like listening to what I was saying. Like she really listened and ... like she said she had time to speak to me which was really nice.*

We found that young women felt able to judge when they needed more support and counselling before making their decision. It is therefore important to offer this service whilst recognising that women have different needs and not assuming that everyone will require counselling.

There were similar responses to the offer of post-abortion counselling, though a number of participants noted that taking part in the research interview was helpful in processing their thoughts and feelings. Annette discussed in her second interview how she had not felt she needed counselling. However, she also valued the opportunity to talk through her experience with a researcher:

it's nice to be able to talk to, I don't know about nice, but it's, I think it's good to be able to talk to someone about it and reflect upon it in, in not such a, like, a counsel, they offer you counselling afterwards, but I don't, I don't think it really needed, I don't, I haven't chosen to have the counselling, I don't think I need to have the counselling. Maybe further on in life, I might end up needing to have counselling about it, I don't know, but right now I can't see that, that will happen, but I think it's good to talk about it in a reflective and constructive way.

Annette's reflections on taking part in the research confirm that she both knows her mind with regard to post-abortion counselling, but that she also remains open to accessing it in the future if those feelings change. This suggests that post-abortion counselling should remain open to women regardless of the length of time since their abortion, and that women should be trusted to know their own minds about whether and when they feel they need to seek additional support.

Choice of abortion method

The young women made a choice between a medical and a surgical abortion for different reasons. Some chose a surgical abortion because they would be sedated and unaware of the procedure, and wanted to

get it over and done with quickly. Sometimes these young women had existing young children at home who needed to be looked after or returned to as soon as possible. A medical abortion was chosen for different reasons and often because it was less invasive than a surgical abortion. Other restrictions on the type of method chosen were due to timing and set week days when surgical and medical abortions were available and accessible.

Other considerations were for emotional reasons and coping strategies. Informal support networks were important to the young women at every stage of their journey, and participants valued hearing about the abortion experiences of others. Danika took advice from a colleague who had also had an abortion:

So I spoke to her about it and she said that she had it and she said that she had the tablets, and she said that they made her feel really sick, and she said that she wanted to puke and if she puked she wouldn't be able to... like basically I felt like if you're taking the pill you're killing it yourself, you're going to bleed it out. ... at the end of the day I'll be knocked out, I won't know. I'm not doing it, it's like I go in and then I come out. And I was just like, at least then I know I am fine, I'm not going to be sick and like, you know, because I don't want to be taking a tablet and then I'm being ill, like what's the point in that? I want it to feel good when I come out, not feel bad about it, and I think that makes it play on your mind a bit more as well because you're awake, you're taking a tablet and you're thinking about what you're doing. And to me I think that's probably more torture for you.

Danika's decision making about the method of abortion she wanted was thus framed around how she would feel after her abortion, and the different emotional and physical burdens of a medical and surgical abortion.

Edie decided to have a surgical abortion after talking her options through at MSI: 'Yeah the lady was nice, because I remember I asked her what's better to have a surgical or the tablets and she told me the surgical was much quicker and... easier. She give me good advice'.

This was not the case for everyone. Britney felt that she needed to press for more information at her initial telephone consultation: 'I felt like I had to ask them. That was a big point actually because I wasn't really aware of the different... the two... like either the pill and how it would work or the operation and it would work. So I don't think they actually gave me much information on the phone call, to be honest.' If the script had been followed Britney would have been given information on the different methods available to her, but it may well be that she found it difficult to understand everything that she was being told. This may be the case for women who had no idea of what an abortion might entail, particularly women who may have found the telephone consultation stressful.

1.5 Abortion experience

Experience at the clinic

The young women were unsure what to expect when they attended the clinic, they were often nervous, and it was important to them that they did not feel judged by centre staff. Their personal perceptions of this often influenced how they felt about their experience as a whole. In general, participants had a very good impression of the centre staff, though this had often not been anticipated. They recalled members of the team being 'nice', whilst often expressing surprise that this was the case:

They are all very friendly and very nice, because I was worried that they were going to be judgemental and look down on me for going there, but they were really nice. (Leah)

Just how lovely the staff were really. I mean they couldn't do enough for me, I mean obviously once I had the ... I wouldn't say it's an operation really, but obviously once it had all happened they offered me a cup of tea and made sure I was alright and like my pain threshold, how badly that was and if I wanted any tablets for it. Any other places you probably wouldn't really get that. (Holly)

However, there were a few accounts that included negative experiences at the clinic. These included instances of feeling judged by staff members, or else the perception that the staff member was in a rush.

The rarity of these instances indicates that they may represent lapses from business as usual, rather than consistent behaviour. The accounts do, though, highlight how young women's experiences can be affected by even a slight lapse in service delivery. Staff morale and well-being can thus make the difference to one woman's journey being a largely positive or negative experience. Alex told us:

It was bloody busy and [the nurse is] stressed out, I'm sure she's sees ten people every ten minutes but at the end of the day I'm nervous and I looked to the nurse for comfort and I didn't get it from her. However, I went back the next day obviously for the second half of the treatment and the second nurse I saw was phenomenal. She, it was less busy, she was lovely, she, I could ask her anything, she was polite, she made me feel fine, she explained everything in great detail and really relaxed me whereas when I left the day before it kind of made me worse and panicky and I thought, 'Oh, what's this going to be like?'

The waiting area was a key point of focus for the young women when they remembered their experience. Many recalled having to wait a 'long time' and there being delays in treatment. It was also described as 'very busy'. Things which participants recalled not liking included: long waits, lots of people, insensitive conversations. Themes also emerged regarding the 'gaze' of other people in the waiting room and everyone being there 'for the same reason'. This exacerbated concerns about a 'lack of privacy'. A few participants recalled seeing 'young girls' who were 'visibly upset' and this made them feel anxious:

You sit in a room full of people and they're all going through the same thing as you while you're waiting for the tablet to dissolve, and there are men and there are women and there are young girls. It was really emotional. There were really young girls there crying and there was mum. It didn't feel right ... I just didn't feel that that was the correct manner to treat people all in that situation. (Jennifer)

Natasha had similar thoughts:

I must say, when I went to Marie Stopes this time, the first waiting room was really busy, and that was really daunting. And then they called me through really quickly, and I was so relieved, I thought, 'Maybe I'll get away from all these people'. Then I sat in this really little room with this lady, and then she said 'Right, go and wait in there'. And then it was another waiting room with lots of people, and I was like, 'Oh, God'. And you sit there and do it yourself, so you know people are doing it about you, 'I wonder what she's here for', you know, 'I wonder if she had a boyfriend or if it was a one-night stand' (laugh). I guess there's no way of really doing it, but this time round, being there, it didn't feel so personal or private, it felt like there was a lot of people there. (Natasha)

Some participants discussed client flow and the experience of being taken from room to room. The women often did not understand why they were not allowed their partner, friend, or mother with them for support during the procedure, and a few were upset because they had to go in alone. Informal support networks were important in helping the young women through their experience in a more positive manner and young women relied on the support and experiences of friends and family. When asked what could have made her experience better Fern, for example, said that she would have appreciated having someone with her. When she attended the clinic she did so with her mother and her friend: *'my friend and my mum came with me so I wasn't on my own, so I got support when I was there.'* However, when she went for her procedure she had to go alone and she would have preferred to have been able to have the support of her mother at that time: *'To have someone up there with me, so I wasn't completely – I felt on my own. I know the nurse and that were there, but it's not like having say my mum sitting behind me or sitting next to me or even just behind a screen talking to me, so then I'd know that someone was there.'* (Fern)

The scan

Undergoing a scan (needed to determine gestation) can be a point of tension. In this study, a variety of views were expressed. Most did not want to see the image, but a small number did, sometimes to help them with their decision-making process.

They don't show you – obviously that's just insensitive to show you – but I specifically asked. ... I

asked to see it. And I knew that was going to be the true decision point for me because if that had looked like a baby, if I knew that there was a heartbeat or anything like that, I couldn't have gone through with it because I think, in my own personal mind... Other people, I'm not going to judge anyone that would go through with it, but I personally couldn't live with myself knowing that it was a real little thing (laughs). In my brain, if I tell myself it was just a bunch of tiny mush, its fine. But it was just a tiny little scoop about this big. (Tara)

Viewing or not viewing the scan was highly individualised. Some participants who had seen the scan image, but who had not wanted to, or had not been prepared to see it, were left upset or angered by the experience.

Yeah. I think when I said that, this was probably the bit that will never ever leave me is when I had this bloody ultrasound and she said, 'Look at it'. And I looked. She goes, 'That's the baby'. And I was just like, 'Why are you telling me this?' That's not the baby because I'm not having it, that's not, no. That's not a baby. A baby for me is fully formed and a baby is something that you would want. And she said, 'Do you want me to print it out for you?' What, as a keepsake? [laughter] 'What do you think I want to do with it?' I will never, ever forget that moment. And then her leaving the room with this photo in my face. (Ahla)

It is not MSI's policy to encourage women to view their scan, and it is also against MSI's policy to refer to the foetus as a 'baby', so Ahla's comments are troubling. Ahla may not have recalled this scenario precisely (this excerpt is taken from her second interview after a number of months had passed), but the strength of her feelings does indicate that, for her, the scanning process was traumatic and might have been handled a little more sensitively.

However, it is important not to assume that all women are reluctant to see their scan images. When Britney was asked how she felt about having the scan she said:

I was fine but I just felt like the lady made more of a problem about it than I did, because the nurse was like... I get it that she was hiding things, like the scan picture and stuff like that, but I asked if I could see it and then she felt like she had to question me on why I wanted to see it and I was just sort, 'Well it's my body'.

These varied responses indicate that no assumptions should be made about how women might feel about having a scan at the time of their abortion, and whether or not women would like to see the image.

Experience of the procedure

Overall women undergoing surgical abortion tended to describe a more positive experience than those who opted for a medical abortion. This was possibly because they were less aware of the process. After undergoing a surgical abortion, participants reported feeling relieved that it was 'over'. Some key themes that were recalled included 'not remembering' and 'waking up'. Saskia told us: *'It was actually fine. I had like slight, very slight bleeding afterwards, which I found surprising because I thought there would be more. But I was fine ... And that was it.'*

A medical abortion was viewed as less invasive. However, participants often commented how 'ill' it made them. It was also very painful.

I was using sanitary towels because I'm allergic to tampons and I had to keep on changing because it was literally I was bleeding so much, and then I started to feel in a lot of pain, like stomach cramps, and I was just using a hot water bottle, and using Nurofen. And then I was in excruciating pain, I just couldn't sleep, like this night, I couldn't sleep, I had diarrhoea and I was being sick at the same time for about five or ten minutes, and it was just awful ... I just couldn't wait for it to be over. It felt like a long, long time. (Dee)

Many of the young women were shocked about how painful their medical abortion had been and felt unprepared for it: *'I didn't realise how bad it was going to be'.* (Cassandra)

The distance to travel to the clinic for two appointments was also problematic, as was taking the second tablet and having to travel home when they were in pain or felt unwell. Annette was accompanied by her boyfriend and when she was asked about his support she replied:

He was very shocked because in the car on the way home, we sort of got stuck in a little bit of traffic and I was literally throwing up outside of the car, like I had to open the door and was throwing up, and he was really shocked with how quickly I was affected by taking the second tablet.

Marlie had an unsuccessful medical abortion, and later underwent a surgical abortion to complete the procedure. This experience made her question her decision: *'It made me question whether I'd made the right decision because obviously it hadn't been successful. So I think had it worked the first time I'd known, I'm a strong believer in fate so that to me made me question, had I done the right thing?'*

2. Post-abortion contraception

Most participants recalled being given advice regarding contraception at MSI, often both at the consultation and then at the time of the abortion. The quantitative research recorded that 79.2% women accepted post-abortion contraception from MSI, with 63.4% of those receiving a LARC method (Bury et al 2014: 28). In the qualitative research strand, there was some movement from user-dependent methods to long-acting methods with approximately half of all qualitative participants choosing a LARC method. Experiencing continued difficulties with finding a contraception they were happy with was a strong theme, and there was evidence of further changes in the months following the abortion. These changes included trying different methods of user-dependent contraception, most commonly the contraceptive pill and condoms. Some women remained committed to their pre-abortion user-dependent contraception.

The purpose of the qualitative research is to seek understandings for what prompted women to make any contraceptive changes; why women may not be willing to accept a long-acting contraceptive; as well as reasons why women did change to a more reliable contraception. This section will begin by considering themes connected with a movement from user-dependent methods towards long-acting methods.

2.1 From user-dependent to long-acting methods of contraception

In this research, the young women who selected a long-acting method of contraception following their abortion had done so for a number of different reasons. An overarching theme in their narratives was their wish to change to what they understood was a more reliable form of contraception.

I chose it [implant] because one of my friends had it and she basically said it was the best one to go for, and then just thinking about – you don't have to think about it for three years, it's just there. So it kind of seemed like the most safe one. (Cassandra)

The different combinations of circumstances that pushed women in this direction included: a self-awareness and/or anxiety that they may forget to take the pill; already having children and being certain they did not want any more; being very sure they did not want to become pregnant again; or that they had not considered a long-acting method before and were willing to try one.

Lara selected the implant sometime after her abortion but she found it difficult at first as it was uncomfortable. On balance, she told us:

It's not as inconvenient as having to remember to take a pill and, you know, have to have an injection every however long it is and have to remember that. The fact that it's there and I don't need to think about it is the best way, I think, because I don't remember anything [laughs].

In this study, some participants found the idea of an injectable contraception off-putting. Some, though, made a positive choice in favour of the injection indicating self-awareness and thought given to making the right choice: *'I don't like the thought of the implant, and I'm very forgetful so the pill wouldn't have worked, and I don't know about the coil, so, I don't know. The injection is the only one that's sort of good, right for me anyway.'* (Marlie)

Paige also selected the injection 'because it lasts longer and you don't have to remember to take it every day, so that was the best option'. She was also very certain that she did not want to become pregnant again.

Jacqui changed her contraception from the pill to the IUS primarily so she 'didn't have to worry about taking the pills or anything'. For her, the abortion was a prompt to improve her reproductive control.

Holly had moved from the pill – which she later thought might have failed because she had been taking antibiotics – to the IUD (which she referred to as the 'copper coil'). She had chosen this because she already had two children, and was sure she did not want any more, and had experienced four unintended pregnancies. She wanted to have a monthly bleed as a signal of non-pregnancy, and expressed high levels of satisfaction with the IUD at both interviews.

It's really handy. You don't feel it or anything and you don't have to worry about taking a tablet each day or going back to the clinic to have another jab, you just get it checked out after you've had it done and then that's it, you just go.

It is important to note, though, that Holly had not felt ready for the coil until she was sure that she did not want any more children, and had been committed to persevering with the pill even though it had failed her on a number of occasions:

I wouldn't go back to that [the pill] but I suppose because I was young, to me it was probably easier for me to have a tablet every day than to have waited till I'd had a period and then go and have a coil fitted, for it to be removed when I wanted kids. Whereas obviously the pill you can stop when you want a kid.

So previously the pill was her contraceptive of choice, it seems, because of the immediacy, real-time, nature of it as a contraception: she did not need to organise a fitting or – it seems more importantly – think about organising removal at a later stage, so in this personal context the pill was more convenient. When she had decided in favour of intrauterine contraception, a major advantage for her was that it was fitted at the same time as her abortion. This was the same for several participants. Fern had an IUS fitted:

They said about the injection. I was like I can't have that because I've got brittle bones and it's meant to be a side effect that your bones get brittle apparently and I was like – the pill was just no, I just ... And they mentioned the coil. I'd never heard of it before. So I was like, "Oh Okay" so they explained all that and I've had the one that's for five years with the hormone and that's probably the best one for your age because it's only for five years so you can decide whether you're going to have another one in or whether you think you're going to be ready after five years because I'd be like 23/24. (Fern)

For other participants, a significant attraction of the IUD was that it was non-hormonal:

I have a funny thing about hormones, so I didn't want to do something ... I didn't want to have the implant because I thought that was too invasive, I didn't want to have the coil with hormones in it, again I thought that was just too invasive. But then I saw the coil and I think maybe because at the clinic the only one we offered was the one with the hormones and I thought, 'Well I don't want anything like that'. But then I realised that there was a coil which is made out of copper and I thought, 'Well that's not too invasive. Yes, it's sort of inside me but it's not a drug' so I asked if I could have that and she said, 'Yeah, of course you can'. So that's what I had. (Ahla)

For Jane, the fact that she could have an IUS fitted at the same time as her abortion was an additional advantage. Jane had selected a surgical abortion because she wanted to be completely certain that her pregnancy would come to an end immediately. She combined this with ensuring that she would have an effective contraception in place. In her case, her abortion and her contraceptive were all done 'in one go'.

The reason I chose that, is because it was done all in one go, I just wanted it over and done with, I didn't want to have to take a pill and then have to take another one, and still think it [the foetus] might be there, I just wanted to know that it was all gone straightaway.

It is important to note that for women undergoing a medical abortion, IUC is not available at the time of their abortion in the same way it is for a surgical abortion. IUC can be fitted at the same time as a surgical abortion, for a medical abortion it requires the young woman to seek it out some time after she has taken her second tablet and is certain that the abortion is complete. The quantitative study found that women who had a surgical abortion were more likely to be using contraception at four weeks compared to women who had a medical abortion (88% vs. 80.3%), and furthermore, were more likely to be using a LARC method (70% vs. 50%) (Bury et al 2014: 37). The administration of implants on the same day as a medical abortion is possible and the quantitative study found an equal proportion of women having a surgical or medical abortion adopting implants as well as the injection. After the second abortion pill in a medical abortion, however, it is not possible for IUC to be inserted and women's choice of contraceptive methods at the time of medical abortion is thereby limited.

This section has thus shown a range of reasons prompting women to move to a form of long-acting contraception, the most important being a desire for more effective contraception. Many, however, showed a preference for user-dependent methods, especially the contraceptive pill.

2.2 Preferring user-dependent methods

The other major theme was a reluctance to select a long-acting method. This could be combined with an assessment that change was not needed. The lack of enthusiasm was likely to be prompted by negative views on long-acting contraception, sometimes this was because they had tried one of these methods before; or because they had heard of negative experiences from friends or relatives. It could also be a combination of factors.

Women's reasons for rejecting long-acting methods following their abortion are similar to reasons given at any other time, in this study and in other research projects (Williamson et al 2009a, Glaiser et al 2008, Tanfer et al 2000). The reasons are numerous. With respect to the implant, some of the young women had already tried this method but had the implant removed because of the side-effects, others expressed distaste at the idea of the method, and some had heard of bad experiences from other people. Tara, for example, had previously had an implant for a year during which time she experienced bleeding irregularities. She told us *'I couldn't have sex because I was "on" all the time'*.

Many women did not like the idea of intrauterine contraception (IUC), primarily because of the need to have it fitted. Natasha made a positive choice, with knowledge of the range of methods, to continue with the pill. She would have preferred long-acting contraception in theory, but rejected the actuality: *'I had already tried the thing in the arm and I really didn't get on with that either [as well as the mini pill], that again gave me really bad spots and just bad skin. So I'd had that taken out anyway and to be honest I would actually prefer a longer-term contraception but just the thought of going to have the coil fitted just makes me feel sick.'* Natasha clarified that this feeling was caused by a fear of pain, and fear of embarrassment. She also rejected the injection because it may take a year for fertility to return to normal, and she was not certain that she did not want a child over the next year. Others rejected the injection because they were scared of, or simply disliked, needles.

Natasha's distaste to having IUC fitted was echoed by several women. Another aspect of this was an aversion to having anything entering their body and a perception that they were not 'in control' of the method:

Yeah, because I am a bit funny with having things put into me that can't be taken out, and staying in me for three months or three years or whatever. I think if you're going to have side-effects on it, with a pill if you have a bad side-effect or bad turn you can stop taking it and it will eventually come out of your system, whereas them you have to get them removed and everything like that. Like until you get that out of your arm or wherever you are still going to get that side-effect, do you know what I mean? I know people that have had a few bad experiences so I think you're better off just sticking with what you know. (Ellie)

Jennifer persisted with the pill, even though she found hormonal contraception problematic, because she thought she was too young to have the coil. She wanted to find an oral contraceptive that did not make her ill. After her second abortion she was determined to stick with the pill.

Eddie decided to continue using the pill following her abortion. She had tried the implant but told us *'it didn't work for me'*. When she was asked why she chose to take the pill again she gave a number of reasons:

Eddie: *There's a lady that I work with that has got the coil in and when she described it, it put me off of it [laughter], so that's why I didn't take that one. I know you can get the injection but I don't know if I'd want that and, the pill just seems like everyone takes it. So, yeah.*

Interviewer: *Okay, so what was it that sounded so bad about the coil?*

Eddie: *I don't know, it just puts me off when they put something in your... it goes into your stomach doesn't it, into the top of your.*

Interviewer: *Well it goes right into your uterus.*

Eddie: *Yeah, that's it, uterus, yeah (laughter), no, puts me off (laughter).*

Interviewer: *Okay, but did she find it alright?*

Eddie: *She had it taken out and she was drawing pictures, showing what it looked like, because it blocks the top of... No, it's not for me.*

Interviewer: *And, you didn't like the idea of an injection?*

Eddie: *No, I don't really like needles that much.*

This exchange illustrates a familiar pattern whereby women are selecting the pill as the 'go to' form of contraception that they find acceptable to them, but they are also aware that this is a contraception more generally accepted: 'everyone takes it'.

It is worth noting that quite a few women were considering IUC but their fear of having it fitted was a deterrent. At T1 interview Annette had decided to have the IUS fitted, and was sure it was the right contraception for her, but a few months later she told us: *'I was thinking of having the coil and then I, I think I just wimped out of the coil and went back for the pill again'*.

Some women who were no longer in a relationship were less likely to choose a long acting method than those still in a relationship following their abortion.

2.3 'Nothing works for me'

One important overall theme was that many women continued to struggle to find a contraception that they were happy with. Jennifer (who had had 2 abortions) had tried a number of different types of pill but they had made her feel very ill, including the one she had been prescribed (by her GP) immediately following her first abortion. That had made her sick every morning. Her GP's response was to suggest that she had *'a look and research other contraception'* which she did but then *'I didn't go forward with anything'*. After her first abortion: *'I was more worried about what was going on in my body than about what I was going to do in the future'* so she continued with the pill as the default option, giving it up for *'natural family planning'* when it made her sick. Similarly Kara found that every form of hormonal contraception that she had tried had worsened her – already extremely difficult – PMT.

We have already noticed that dislike of hormonal contraception dramatically narrowed down many women's contraceptive choices. This was an important theme in this research.

Kara had carefully thought through all her options:

Basically I've been to the doctors about my PMT problems before and I know that the pill makes it worse. I've tried progesterone only, I've tried oestrogen only, I've tried mini pills, I've tried ones that

give you a period, ones that don't give you a period, you know, I've tried a lot. Some that made me feel really sick, some that made me feel really depressed, and you know some that just made me feel up and down in general, and just kind of, I mean, I don't know, maybe that was because I was younger and I was not happy in general. I just find it just makes my PMT very intense ... and I notice the difference between when I'm on the pill and when I'm not, I mean they offer you the injection, the implant, the coil, all the rest of it. I just saw it as not enough options really. I think it is actually quite, even though there are a few different method, you kind of have to either go for you know synthetic hormones pumped in your body, for months, or an injection of the same kind in your arm, or you know the implant. It's all hormonal based and that really messes with me, and I don't, I don't like it. I don't like, I just don't really like having that in my body, so that's why I would go for condoms because to me they're like the most sort of natural kind of method ... the copper coil is like the only other kind of non-hormonal contraception that I know about, and I suffer from really, really heavy and bad period pains.

Kara had reached a conclusion that suited her: *'so basically I don't want to take any hormones, and I suffer with bad periods, pains and heavy bleeding. My only option is condoms really'*.

2.4 Contraceptive shifting following abortion

As would be expected, women who had difficulty finding a contraception that suited them switched their contraception often, and this did not necessarily change following their abortion. Larissa, for example, had tried *'every single brand of pill'* over the course of about 10 years, as well as trying the implant. Her contraceptive choice after her abortion was to try another brand of pill, but by the time of her second interview she had an IUS fitted. Her account is almost of desperation to find something that suited her, and that could alleviate, rather than aggravate, her problematic periods.

I was always really against it [the IUS], I don't know why, I just thought it was a bit like invasive. But I was in absolute agony and it was one of the last things I could try with regards to trying to calm down my periods and stuff. So, yeah I thought I'll give it a go and I thought if I don't like it I can always have it taken out again. So I went ahead and had it fitted, it was in January, and since then, touch wood, I've not really had many problems.

Becky moved from the implant to the pill (she became pregnant when her implant was due to be replaced). She did not want another implant because she was planning a pregnancy in the next year.

Overall, the reasons why some women do not select a long-acting contraception following an abortion are very similar to those given prior to their abortion experience. However, that does not mean that there was no contraceptive or sexual behaviour change. Movement to alternative user-dependent methods occurred, as did resolutions to ensure that contraception was used more consistently. Lucy, for example, moved from condoms that were used rarely to stating that she would definitely be using condoms all the time.

Ellie had moved from no contraception, to the pill following her abortion, though she is not sexually active. She rejected LARC but stated that her approach to using contraception had changed completely:

Then yeah, definitely, it has totally changed my outlook on things because you don't realise how easily things like that can happen, and it's not until you either do have a massive scare or you go through that whole thing that I went through that actually gives you a kick up the bum to just say do something about it.

At the time of her pregnancy, Danika was using condoms but she then decided to use the cap in addition to condoms:

Because then it's like twice as secure. I don't think I could trust it without, do you know what I mean? It probably would work without but I would still be a bit like, you know, you don't know, so two ways is better than one I think. So yeah, I think that'll be a lot more secure for me.

Many, such as Megan, had started using a phone app with their pill to help them take it systematically.

2.5 Selecting post-abortion contraception at the abortion clinic

There was a mixture of responses to the contraceptive advice participants were given at MSI. Some valued the advice, and welcomed being given a strong steer.

I thought about going back on the pill because I was kind of freaked out about having a stick inside my arm but my best friend is on it as well and she said... and then they convinced me, they were saying like, you know, it's the most effective method. Like obviously they weren't trying to say, 'You have to get this' but they were saying with the pill you can forget about it and this can all happen again but with the implant you just don't have to worry for three years really. (Cassandra)

As mentioned earlier, Cassandra was attracted by the reliability of the method. These comments indicate how a combination of advice at the clinic, and her friend's views and experiences were important factors in helping her decide to try the implant. She reinforces this in her second interview, at which point in time she was still using the implant – and intending to retain it – even though she was experiencing irregular bleeding.

Reluctance to discuss contraception at the abortion clinic

Jennifer struggled to find a method of contraception that suited her. She worried about side-effects and was exploring having an IUD fitted. However, she was not using anything when she became pregnant (although she had sought out EHC) She had a medical termination, and had found the experience distressing. She relied on the support of her boyfriend throughout the experience, noting that he also was 'very shocked' by the experience:

I wouldn't have been able to do it on my own at home. Because it was very em-, I felt very, very emotional and I felt very [pause] it was very painful and I felt very emotional and I couldn't have been able to sit there and do it on my own.

Such experiences contributed towards reluctance, for some women, to consider contraception at the time of their abortion. Jennifer was not an isolated example, and the rationale given for this reluctance by Jennifer, though she has difficulty articulating it, gives an insight into why some women may be reluctant to think seriously about their future contraceptive needs at the same time as undergoing an abortion:

Even though it's explained, it's never explained enough and the condom seemed to be like the first point of call and I don't know. I just don't. I just, I haven't really, I didn't feel like, I feel like that mostly they are really good and they are really good in there. But they're there to do one job, and that's how I felt when it came to having, talking about contraception or counselling or anything like that.

This indicates a reluctance to think about anything else at the time of the abortion, a reluctance that was evident with many of the women interviewed:

The abortion clinic. They're really like, you can't leave without making a [contraceptive] plan. They don't let you leave ... And it's just like, woah, you know, I've just had an abortion, you know, leave me alone. The last thing on my mind is what I need to do to protect myself when having sex. I don't really want to have sex, you know. (Lara)

We found some relationships between the young women's emotional response to their abortion, and their post-abortion contraception. Those, like Jennifer, who found the entire experience particularly difficult were more likely to be unable to focus on contraception at the time of their abortion. MaryAnn, for example, was also upset by her abortion, didn't seek effective contraception, and was pregnant again at her second interview. By way of contrast, Ahla was sure about the decision she had made, felt relief and not regret, was able to engage in a contraceptive consultation, and went on to use an effective form of contraception.

Another explanatory theme was the need for women to know more or have more time to think about what they were being offered:

They wanted to put an implant in my arm right after it but I just thought that I didn't want to do it that

same day. So I got it done at another clinic a couple of weeks later. (Saskia)

I was offered a free contraceptive but I didn't take any because I really wanted to look into and read up on it, on the ones that she gave me on the piece of paper, and also speak to friends or family to who's had what and whether or not it's been effective and worked. To be honest with you, I am going back on the pill, I don't want any of the other ones. (Ellie)

Another contributing factor for some women, as with Ellie, was the need to have some knowledge of the contraceptives being offered. This was another factor that was important to MaryAnn. She had some views on the implant before her abortion and had decided against it, but did not consider IUC when it was suggested:

MaryAnn: *They offered me one of them [implant] but I didn't like the sound of them, like the injection I'd think I'd find it hard to get to the doctors to get the injection, however urgent it is. I didn't like the implant, one of my friends has got it and she had quite bad infections from it in her arm and I didn't just like the sound of something in my arm, it didn't sound nice.*

Interviewer: *Yes, so the coil, did they offer that? What do you think about that as a method?*

MaryAnn: *Yes, I don't really know that much about that one, so I just kind of said, 'No', to it.*

As noted earlier, MaryAnn left the clinic without a contraceptive method (she became pregnant between T1 and T2 interview).

One other issue that emerged was that some women were not aware that they could have had IUC fitted at the time of a surgical abortion. For example Edie told us: *'I didn't know you can have it fitted at the same time'*. This may have made a difference to their aversion to the fitting itself. We are not able to comment on whether this was because they had not been informed or whether they had not retained everything they had been told.

Although the view that they needed to wait for their body to 'return to normal' was not confined to the women who had selected a medical abortion, it seems as though some young women who had opted for a medical termination had particular difficulty in establishing their post abortion contraceptive regime. This was for a number of reasons. For some, as in Lara's case above, contraception was not at the forefront of their mind when they left the clinic. For the women who had a medical abortion, they were yet to complete their termination and this may have played a role. Finally, we have noted how many of the participants felt very ill following their medical abortion. These observations help to explain the quantitative findings that women who had a surgical abortion were more likely to be using a method of contraception four weeks after their abortion than women who had a medical abortion (Bury et al 2014).

3. Multiple unintended pregnancies

One of the questions we addressed in this project was: can we explain multiple unintended pregnancies amongst young women? Of our sample of 36 women, we had a sub-sample of fifteen women who had experienced at least two unintended pregnancies. Some women had also experienced intended pregnancies. Intended (and some unintended) pregnancies had resulted in motherhood. Two participants had also experienced a miscarriage. In this section we are going to focus on those pregnancies that were unintended, and that ended with abortion (or miscarriage in one case). Some of these women were interviewed twice. As with the whole cohort, our analysis was case based and thematic.

Previous UK quantitative research (Stone and Ingham 2011) located some predictors of subsequent abortion. These were mainly related to sexual behaviour (women are more likely to have been younger at first sexual experience, been poor users of contraception at first sexual experience and had a greater number of lifetime sexual partners). Our quantitative part of the study did not identify any specific groups of young women among our sample who are more likely to have more than one abortion, with the exception

of age-related factors. In the qualitative study we found a diverse range of situational and behavioural scenarios in which women experienced more than one unintended pregnancy. Though one of the aims of the research had been to try and identify particular categories of young women more likely to experience multiple unintended pregnancies, the diversity of experiences was such that we were not able to develop a typology of these women beyond the obvious observation that contraception was not being used effectively. Beyond this, there is a multi-faceted story behind each individual in the sub-group. We also found that these stories change for each pregnancy, so that we did not find evidence for a continuation of previous behaviour. We will use a number of case studies to explore this in more detail.

Carrie, aged 22

Carrie went to a convent school where there was no sex education. She became sexually active when she was 16 with her first boyfriend who was 17. They sometimes used condoms, but she didn't think about the possibility of becoming pregnant *'until it happened'*. Carrie was 16 when she became pregnant the first time and decided to have an abortion because *'I was too young and still a kid myself'*. At around the same time she split up with her boyfriend. She was not sexually active again for two years, although started a new relationship about six months after her abortion. *'I was properly worried, really worried, about it all happening again'*. Later, Carrie and her boyfriend talked about a sexual relationship and contraception, and she decided to go on the pill. She did not expect to become pregnant again, and still does not know what happened. Her doctor suggested it might have been because she had tonsillitis and was taking antibiotics – *'I was devastated, proper devastated, a bit hysterical'*. Because Carrie and her boyfriend had been together for a while, and had just got a flat together they decided to go ahead with the pregnancy. After she had her son, Carrie started on another pill because she was certain she did not want to become pregnant again; but after a few months she felt ill and was pregnant again. She does not know how this happened – *'I just don't seem to have any luck'*. This pregnancy ended in abortion.

Carrie was, and still is, troubled by her first abortion. She had not wanted to have an abortion and been *'forced'* to by her mother. She would probably have gone ahead with her pregnancy, though she now says *'that would have been a mistake, it really would have been'*. She had delayed telling her mother until she was about 16 weeks pregnant and had an abortion at 18 weeks. Carrie is now certain that it was the right thing to do, reflecting that *'that says it all, that I had to tell my mum. I obviously wasn't ready to be a parent'*. But she does also think that if there was more open talk about abortion then she might not have been so worried about discussing her pregnancy with her mother.

Holly, aged 22

Holly has had four unintended pregnancies. She has two children and has had two abortions, all with the same partner, her first boyfriend with whom she now lives. She was first pregnant at 16. They were using a condom which *'must have split'* because she did not expect to become pregnant. She had an abortion and switched to the pill for her contraception. She was careful taking it and it worked for her for two years but then she found herself again pregnant, and again without understanding of why at the time. She later thought the pill could have failed because she was on a course of antibiotics. This time she was happy to proceed with the pregnancy, as she was with her third pregnancy which was also unintended and also happened when she was on the pill – for this pregnancy she could not recall, or imagine, any reason why the pill may have failed. But having experienced three unplanned pregnancies she decided to have an IUD fitted. She was very busy and happy looking after two small children. Holly was still sexually active and using condoms, rather than the pill, as she was sure she did not want to become pregnant again. She had two appointments for IUD fitting cancelled and then discovered she was pregnant for a fourth time. When asked to reflect back on her contraceptive use, she did say that sometimes she had found it difficult to remember to take the pill every day. Holly was reliant on non-specialist services for her contraception, and did not appear to have considered any long-acting method apart from the IUD which she had not wanted to have fitted before she felt her family was complete.

Natasha, aged 24

Natasha's first form of contraception had been the pill which she was initially using to control her periods. Her first sexual encounter was at 15 and she continued to use the pill for several years until the birth of her child. Natasha has been pregnant three times. The first time she became pregnant she says there were about *'six months where I was naughty, went off the rails a little bit and did the whole rebellion thing, and I just stopped taking my pill'*. This pregnancy ended in an abortion.

She became pregnant a second time in a long term relationship and decided to continue with the pregnancy. Her most recent pregnancy occurred after 'unexpected sex' with her ex-partner. She had just finished her pack of pills and was aware that she might be at risk of pregnancy. She sought EHC, but it did not work for her. She decided an abortion was the right choice for her and her child and booked in at the clinic. However, she started bleeding five days before her appointment and when she went to the clinic she was told she had miscarried.

Leah, aged 19

Leah started having sex at 13 and was using the pill for contraception. She had a number of short and casual relationships before meeting her first long-term partner at 16. Whilst in that relationship she decided to have the implant fitted. She kept the implant for 3 years. Leah then had to have treatment for ovarian cysts and was advised by the doctor not to take contraception until after her next period, but in the end she did not access contraception at all. Leah and her partner were using condoms sporadically but after they *'got away with it a few times'* they just *'got a bit stupid'* and did not use them. At 18, Leah became pregnant and kept the baby. She moved in with her partner who supported her choice. After Leah gave birth, she suffered from post-natal depression, and it took her a while to bond with her daughter. She had started the pill again but took it later than she was meant to one day. She then went to get the morning after pill as a precaution. Later, she did six pregnancy tests which were all negative, but decided to visit the doctor because she had not had a period since the birth of her child. The doctor did a further pregnancy test which was positive. Leah was very upset; she felt like she had taken every precaution necessary and yet for the sake of a few hours she was pregnant again. She really had not wanted to get pregnant again, especially considering her previous post-natal depression. She felt that coping with two children under the age of one was not an option and so decided to terminate the pregnancy. She expected to feel sad or guilty after the abortion and was surprised that she felt fine. This confirmed to her in her own mind that it had been the right decision for her at that stage in time because she had just started to form a relationship with her daughter, and that was ultimately the most important thing to her.

3.1 'It won't happen again': behaviour change between and after unintended pregnancy

The range of factors behind unintended pregnancy (discussed earlier in this section) was also evident for subsequent unintended pregnancies. Other women recalled failed condoms; being between injections; behavioural related factors and not using contraception; having an eating disorder; and unexpected sex. However – in the main – for individual women, their particular circumstances had changed so that the stories behind each unintended pregnancy are stories of change. The earlier themes and scenarios which lead to unintended pregnancy are therefore repeated, with one exception. Most women no longer thought that 'it won't ever happen to me', but they had taken steps to ensure that 'it won't happen again'. Holly, for example, had changed to the pill which she hoped would be more reliable. Some other factor led to a contraception failure on these subsequent occasions.

One important theme in multiple unintended pregnancies was the belief and hope, following one abortion, that they would not become pregnant again. This was for a variety of reasons, but a change in behaviour underpinned these reasons. For most women, there was a different situational and behavioural scenario behind each pregnancy, as opposed to a similar one. Often there was a change in contraception in a response to their pregnancy and abortion. But – as would be expected from a cohort of women experiencing more than one unintended pregnancy – they were not using contraception effectively. Several had initially moved to a long-acting method but had not been satisfied and had discontinued,

mainly moving to the contraceptive pill. One thing that was particularly striking with this sub-group was the strength of the theme of unanticipated sex, discussed earlier for the full sample.

4. Longitudinal interviews: Contraceptive changes over time

This section looks specifically at the 17 longitudinal interviews (just over half of participants gave a second interview). It will explore post-abortion contraceptive use over time with a specific focus on why participants continued to use or stopped/swapped the method of contraception they received from MSI after their abortion. As can be expected there was a mix of stopping, swapping, and starting methods, as well as continuing with the method given at MSI. This depended on the young women's satisfaction and tolerance of the method received, and also relationship status, and motivation to avoid another unintended pregnancy in the future.

4.1 Still using method given at MSI

Earlier we have discussed how Cassandra opted to have the implant inserted after her abortion. At her second interview she was still using the implant although she was not entirely satisfied with it because she was experiencing irregular bleeding. Cassandra said she would go back to the doctors if it became problematic, but at the moment it was *'manageable'*. She envisaged that she would continue with the implant for the full 3 years, although after this she might try the injection. She was very motivated to avoid another unintended pregnancy and this was the driver in her tolerance of a method she was not entirely satisfied with.

Similarly, Ahla definitely wanted to avoid another unintended pregnancy, and self-identified as being very career driven. She had a surgical abortion and had an IUD fitted at the same time. She was still using the IUD and was happy with the method. At her second interview she described having had a number of sexual relationships, although she did not always use condoms. Ahla said she finds it difficult to suggest condom use and gets carried away in the moment. She perceives her risk of contracting an STI from her sexual partners as very low because she believes them to be *'clean'*.

Carrie was another participant who was still using the IUS given to her at MSI at her second interview. In contrast to Ahla, however, she was not sexually active although had made a decision to continue with her contraception because it is *'better to be safe than sorry'*, and she would *'rather not go through the hassle of getting it taken out'*. One of the draws to having the coil fitted in the first place was that it could be done at the same time as her abortion. She intends to continue with the IUS for the full 5 years.

From the above examples, we can see that a strong determination to avoid another unintended pregnancy is a factor in the selection and continuation of a LARC method of contraception given at MSI. This can include the toleration of a method, like Cassandra, that they are not wholly satisfied with. This suggests the balancing of a desire to avoid pregnancy with the toleration of side-effects. For other participants, the experience of side-effects motivated them to swap methods, as discussed below.

4.2 Swapping methods

Some participants had swapped the method they received from MSI (by their second interview) because they were unhappy with the contraceptive, but were still very motivated to avoid unintended pregnancy. They often returned to a different provider (usually their GP) in order to access this. These participants usually returned to a user-dependent method (the pill) from a LARC method of contraception. Sometimes they had experienced side-effects or problems with their LARC method which they were unable to tolerate.

After her abortion Fern considered the IUS and the injection. She decided on the IUS as she had brittle bones. She had it fitted at the same time as the termination. By the second interview she had had her IUS removed on the advice of a gynaecologist because she was experiencing problems with increased discharge. She was now using the pill as her contraceptive method, after a brief period of condom use at the beginning of a relationship.

Maddie was relying on condoms for her contraception when she became pregnant. After her abortion she had selected the injection as her method of contraception and had it administered at the clinic while she was sedated. At her second interview, Maddie told us that she had swapped to the pill (COC). She was not happy with the injection because she felt that it caused her to gain weight, get spots and experience mood swings.

Other participants had changed to a more reliable method, although these were fewer in number. Larissa had become pregnant when she had sex unexpectedly after the end of her relationship. After her abortion she returned to the pill as her method of contraception, regardless of the fact that she was not sexually active. At her second interview Larissa spoke about her problems with ovarian cysts. In light of this she had swapped her method to the IUS, a method she had previously rejected, to try and control heavy painful periods:

I was always really against it, I don't know why, I just thought it was a bit like invasive. But I was in absolute agony and it was one of the last things I could try with regards to trying to calm down by periods and stuff. So, yeah I thought I'll give it a go and I thought if I don't like it I can always have it taken out again. ... It was just a case of it was either having the Mirena coil fitted or keeping on with the really bad periods.

There was a trend, though, for some participants who made a switch from a user-dependent method of contraception to a more effective LARC method at the time of their abortion, to switch back to a user-dependent method after a few months.

4.3 Stopping contraception

Reasons for discontinuing with contraception received at MSI were often linked with the end of a relationship. There was a notable resistance, in particular, to retaining a long-acting method when it was not considered necessary. This mirrors some young women's willingness to tolerate a method they are not entirely happy with in order to experience reliability. As mentioned earlier in the report, Jacqui had changed her contraception from the pill to the IUS. However by the her second interview she was planning to have it taken out:

It just don't agree with me. I don't have periods. I'd rather have periods. I just want my body to go back – because I think for years I've been either on the pill or on the implant or anything and I just want my body to actually go back to normal ... Sounds weird but just my body's not functioning properly if they're not, my eggs are not ... I mean first of all it did sound good, because of not having to worry every month, but now I just want my body to go back to normal.

Jacqui was no longer in a relationship and did not want to select contraception until she was in another relationship, but as can be seen in her rationale, she was also keen to prioritise her natural body over her need for contraception at that particular point in time.

4.4 Continuation with previous method

Kara also disliked hormonal contraception, but unlike Jacqui she was in a sexual relationship. After her abortion she did not leave with a contraceptive and was using condoms as her method. She was unwilling to take a hormonal contraception because she disliked hormonal contraception: *'I don't think there's enough options really. You kind of have to either go for you know synthetic hormones pumped in your body, for months, or an injection of the same kind in your arm, or you know the implant. It's all hormonal based'*. She had considered an IUD but had discounted it because she feared that it would make her periods more painful. Kara was frustrated at the lack of available contraception that suited her needs: *'It's really difficult, because I know that I don't want the coil, because I know it would be very painful for my periods and I know that I don't want to be on any hormonal kind of contraception, so I don't ... There isn't really many other options'*.

At her second interview Kara was still very frustrated with the lack of non-hormonal contraception available to her. She was continuing to use condoms but her partner was not happy with this method and she described having arguments with him over her resistance to going on the pill or using other hormonal contraception or the IUD.

4.5 Starting contraception at a later stage

In our quantitative study, 79.2% of participants left MSI with a method of contraception. The figure was slightly higher for women undergoing a subsequent abortion than those who had had one for the first time (82.6% vs. 77.9%). Of the total number of women taking part in the survey, 85.6% were using contraception at 4 weeks post-abortion (Bury *et al* 2014: 24). In the qualitative study, we also spoke to a number of women who had started contraception sometime after their abortion.

MaryAnn was a participant who did not leave the clinic with a contraceptive. This was her first abortion. After her abortion MaryAnn was thinking about getting the pill from her GP. She had been relying on withdrawal as her method, but had thought that it '*wouldn't happen again so soon*'. At her second interview MaryAnn told us that she had become pregnant a second time, about a month after her abortion. After her second abortion she received the pill (POP) from the clinic and started to use this method.

Annette was using condoms after her abortion. She had previously had problems with the pill and was considering other options:

I don't think I want to have the pill again, really, because it – I'm still waiting to see if it affects my water retention. But I've been recommended the coil by a lot of people that I take their opinions – I value their opinion. So that's one of the reasons. And also I think – I'm in a long term relationship, so I think that's fine for me. I know you shouldn't have it if you're changing partners. Otherwise I'm considering maybe having the injection, but I'm not too sure. I think I need to go and discuss it all, really.

At her second interview, Annette had sought out the pill (POP) from her GP. She had waited until after her second period post-abortion. However, she was no longer using this method because her relationship had ended.

We can see in all these different patterns that with regard to post-abortion contraceptive use in the longer term, changes are individualised. Contraceptive use is linked to relationship status, although there are other factors. Some participants who were very keen not to have another unintentional pregnancy continued with their contraception, despite not being sexually active. Others stopped and started methods dependent on their relationship and consistent 'need' for contraception. Again this has the same issues as pre-abortion contraception use/non-use. Stories have some similarities, but each participant has more than one story which results in a collective narrative of trial, error, and success, in exercising reproductive control.

5. Post-abortion emotions and stigma

The young women interviewed experienced a range of post-abortion emotions. Leah described feeling accepting of her decision.

I just felt normal. It was really weird. I didn't feel like I'd had anything done and I was waiting for the pain, and the emotions, and everything to come, and they just never have. I don't know if it is because I think I knew in myself from day one what my decision was going to be, so I had prepared myself and I kind of like switched off the fact that I was pregnant, I don't know, but I felt fine, It was really weird, it was a really weird feeling because I was waiting to feel upset, and start hurting but I didn't.

Leah had been very clear on her decision to have a termination. She suggests that this may have influenced her post-abortion feelings. Ahla had similar feelings and she too was comfortable with the

decision she made. In Ahla's case she reflected on the process of taking part in the research, which acted as a trigger for her to return to thinking about her abortion:

I suppose any time I've thought about this, these interviews, I've thought about, I've always done a little sort of clock back as to when it was. And so for example, yesterday also when I realised this interview was today, that I did the maths and counted back and saw where I would have been if I didn't have my abortion. And then that obviously led me to think about where I would be in the cycle of having a child. And led me to thinking about how thankful I was that I didn't.

Other participants reflected back on their experiences and what might have been:

I did feel like, that could have been a baby, but then I also thought, how could I have looked after that baby? I wouldn't have been able to do what I'm doing, like going to uni, I don't want to end up having a loan from uni which I haven't finished and having a baby that I can't afford, when I want to give it everything. (Danika)

Some also thought about motherhood:

I'm one of those girls that are like having a baby is something that I think... it sounds really silly, like to come from a 16 year old, but if I was to have a baby now, like actually have one, I reckon I could like be fine with it. Like I reckon I could be a young mum. (Megan)

Importantly, abortion-related stigma was a feature in all of the women's recollections of their abortion journey. However, the degree to which they felt this stigma differed between participants. Natasha's account demonstrates how common discourses about the young sexual body and stereotypes pepper the young women's accounts and views of themselves:

I just felt [pause] like a bit of a slapper. You know? Like, it's not difficult. Contraception is free. It's not difficult to come by, and if you don't want to go to the doctor's there's ... I mean I know this area really well and there's places all over the shop where you can access contraception. And you know, I just felt like a bit of a wrong 'un, you know. You're 18 and you're pregnant, that's disgusting to start with, you know, and I guess a few of my friends had done that, and become pregnant and had children, and I was just like, "What are you doing!" And I did really judge them. And then I was there in the same boat, and I was so embarrassed [pause]. (Natasha)

Many participants resisted stigmatisation and explained their decision based on their situation and circumstance at the time of becoming pregnant, especially in relation to notions about the right time to become a mother. They discussed moralistic views that it is only 'right' to have an abortion in certain situations; and that it should not be used as a form of contraception. This was perhaps as a way of deflecting broader societal judgements, and thus resisting stigma. Most said that they 'wouldn't do it again'. Many regretted having to have an abortion, but not the procedure itself, although a small minority did struggle with their decision afterward.

Abortion, in general, was seen as a 'bad' thing to do and many women spoke in terms of having 'learnt a lesson'. Participants sought out support from various sources – either friends or family who have had an abortion in the past, or else the internet. Again, the seeking out of support through informal support networks was important.

My colleague, who I work with, she's a very good friend of mine, she's had abortions before and I know how she felt going through it and, but I'd never thought about it in my own sense, as me actually having one. Like, she, I was there when she had hers and when she went through everything with her, and I see how she was, she was very emotional about it, but at the same time, her circumstances were the same as mine ... Watching her go through it was a bit, it made my decision a little bit easier because if she can do it, then I could do that and handle the emotional side of it as well. (Jennifer)

Popular discourses about abortion had been internalised and influenced how the young women felt about their decision. Participants discussed the moral framework around abortion and defended their choice for doing it for the 'right' reasons. They drew on notions of 'right' or 'wrong': for example, abortion is acceptable in certain situations if a woman has a contraceptive failure, but to use abortion as a form of contraception is unacceptable. Participants wanted to set themselves apart from stereotypical views of feckless young women. Gestation was also an important factor – they felt that the earlier they had the abortion the better. Many spoke of being 'only 6 or 7 weeks' pregnant.

Shame was a powerful emotion. Although stigma and shame feature in almost all the young women's accounts of abortion, in the subgroup of women who had experienced multiple unintended pregnancies and abortion, there was a stronger sense of failure and self-blame: as Natasha put it, 'once is bad twice is unforgivable'.

I thought, "Three times, that's really, really bad" and I thought to myself, you know, "I can't really blame myself because I'm on contraception" and I've been using condoms now and again, like obviously not all the time, but I use the Cerazette and I also took the morning after pill with this one.
(Gemma)

Here Gemma is voicing a common stigmatising perception that having more than one abortion carries additional shame, it's 'really really bad', but she is resisting the stigma through a rejection of blame.

Across the sample, there was a lack of awareness about how many women experience abortion in their lifetime. When faced with the statistic of 1 in 3 women in the UK have an abortion, many participants were shocked to hear how common it was. This demonstrates a need to raise awareness about this aspect of women's reproductive healthcare, as well as to combat abortion-related stigma.

In addition, many participants also noted that the presence of protestors outside clinics made them feel upset and angry:

I remember there was loads of protestors outside and that quite upset me, loads of people outside saying, 'Don't get rid of it' and all that sort of stuff. (Gemma)

Before I went into the thing there were these protestors outside ... this guy came from the front, he seemed like a really nice guy to me and that, then he gave me a leaflet, and I was like, fine, and then I went inside that and then I opened this leaflet and I was like, why are you even giving me this? My mum took it off me and she was like, 'Don't read that stuff'. And I was like, 'I'm not going to'. I was like, 'How could he even be outside there?' (Danika)

These accounts underscore the importance of finding ways for women to enter the clinics without harassment and further stigmatisation.

Conclusions

Throughout this report, we have emphasised the variety and complexity of the circumstances in which women become unintentionally pregnant. The qualitative study has enabled greater insights into factors related to why women may experience one or more abortion including: reasons why women select, or do not select, particular forms of contraception; the current limitations of emergency contraception; and on the importance of women's sense of bodily well-being for all these choices. One limitation of the study was that the sample was not demographically – especially ethnically – diverse.

Overall, in common with the quantitative branch of the study, it has not been possible to identify a particular 'type' of young woman who is most 'at risk' of unintended pregnancy, or more 'at risk' of a subsequent unintended pregnancy. It is important to recognise this complexity because it indicates that there is no 'silver bullet' that could be proposed as a solution if abortion is perceived as a problem. There are, however, a number of important themes, that can now be highlighted, which point to particular recommendations. The overall focus is on what may help women improve their reproductive control.

For each of these women, something could be identified that would have helped them avoid becoming unintentionally pregnant, but this would not have been the same for everyone. We have outlined situations in which young women could not imagine becoming pregnant. Their perceptions of their own fertility had led them to believe they could not become pregnant. Our second category concerned women who were also shocked to find themselves pregnant. In these cases this was because their contraceptive had failed them but they did not fully understand why. Their own explanations: 'maybe I missed a pill'; 'it must have been the antibiotics' indicate uncertainty and poor understanding of what went wrong for them. Some women in this category, though, had realised they had not used contraceptives correctly (others had simply not been using contraception) but they had accessed emergency contraception and that had not worked. Finally, we identified a larger more diverse category encompassing women who had been aware they were not using contraception consistently and had (mis)calculated/hoped that they would not become pregnant. The two strongest themes in this final category were complex personal lives and relationships; and difficulties with known contraceptive methods.

One seemingly straightforward solution for many of these unintended pregnancies would be to suggest greater promotion of LARC. Ensuring that women can access LARC easily is certainly important. We have seen that this type of contraception was acceptable and embraced by some of our participants, particularly immediately following their abortion. This was because they wanted a more reliable and effective contraception, and were prepared to try a form of LARC, most often the implant. Additionally, participants, who had become pregnant without ever trying a long acting method, may well have tried a LARC (rather than the pill) had they been aware of – and able to access – the full range of contraceptive methods when they had been sexually active. However, our findings have also shown that this is not always the case. Our findings, concurring with other research (Walker 2012; Newton and Hoggart 2015), show that some women are reluctant to try long-acting methods and/or do not like hormonal contraception. For some women, therefore, LARC may not be the preferred type of contraception. Our findings also indicate that a reluctance to try a long acting method may continue following an abortion. Both these categories of women – those willing to try LARC, and those who are not – need to have their contraceptive choices respected at the time of their abortion.

In addition, this research has highlighted women's desire to change their contraception when it suits them. This may be because they are struggling to find a contraception that they are happy with, and they are trying to find something that works for them; or because something changes in their life. In particular, the longitudinal research has enabled us to see how women can be quick to change, or simply discontinue, their contraception if they are not happy with it for any reason. The most likely reason to change or discontinue from LARC was due to undesirable side-effects. This indicates that all services need to be prepared to offer women a full range of contraceptives together with detailed counselling about the side-effects they may experience, and what can be done if these become problematic. This information should be backed up in written form. Some forms of contraception were rarely mentioned – the contraceptive

patch for instance – and this suggests that these young women may not have had the opportunity to consider whether these forms may have suited them.

Unanticipated sex is a major theme in this study, particularly evident in women who have more than one abortion. Most young women we interviewed would not have wanted long-acting contraception in place when they were not anticipating being sexually active. This is the circumstance in which emergency contraception can be utilised, but we found poor knowledge and understanding about emergency contraception, including a number of cases in which it had failed. Both brands of EHC are likely to be ineffective immediately following ovulation; and it is likely that the timing of unprotected sex in relation to ovulation is more important than the number of hours which pass prior to taking emergency contraception (Glasier *et al* 2011). After this point a copper IUD is a much better form of EC. We found very poor knowledge of the IUD as emergency contraception.

It is difficult in a short report to bring out the variety and complexity of these young women's narratives. What we can say with certainty, though, is the complexity that we have been able to illustrate, points towards the importance of multi-faceted contraceptive and sexual health services that are able to respond to women as individuals, to signpost them to other services if necessary, and – above all – to try and ensure that women feel comfortable to return to services to request a change in contraception if they wish.

This study has also confirmed how important it is to try and ensure that women's abortion experiences are as stress-free as possible. In general, women reported favourably on their experiences at the clinics. Two areas where many of them would have wished for something to have been different were: the lack of privacy in waiting rooms, and being separated from whoever was accompanying them when it was time for them to have their abortion. Our analysis also indicates that some of the reluctance to consider a change in contraception at the time of their abortion could be associated with their experience of, and feelings about, the abortion. This contributed towards women finding it difficult to consider contraception at the time of their abortion, and reluctant to engage with practitioners who were trying to discuss contraceptive options with them. Some women are unable to focus on contraception at time of their abortion, and there are some indications that a medical abortion further complicates this process.

The research has also shown how abortion-related stigma can be an issue for some women. If this finding is considered alongside recognition of the complexity of women's sexual and reproductive lives, the research findings suggest that a conceptual shift away from seeking a solution to the 'problem' of abortion towards considering how all women might be helped exercise more effective reproductive control would be helpful.

It is also important to acknowledge that unintended pregnancy will be experienced by many women for a wide variety of reasons and hetero-sexually active women will need access to abortion as a normal part of their reproductive healthcare.

Recommendations

It is important for all service providers to acknowledge and understand abortion can happen to any woman at any time in her reproductive life and for a variety of reasons, and that how women experience abortion can be very different. We have suggested that although there is no 'silver bullet' to help women improve their reproductive control, there are measures that can be taken which could help achieve this. This requires complex responses to complex situations. Alongside the recommendations from the quantitative report, we have the following recommendations from the qualitative research:

- 1. Ensure a full and comprehensive contraceptive consultation, and provision of a full range of contraceptives, at the abortion provider.** As noted in the quantitative report, this requires systematic and adequate commissioning of contraceptive consultations and contraceptive provision at the abortion provider. If a woman's chosen method of contraception is not available or she is unwilling to discuss contraceptive advice, then providers need to supply a suitable bridging contraceptive method, provide a supply of EHC, and encourage women to attend their local services to access their preferred method.
- 2. Establish a referral pathway for those women who leave the clinic without a contraceptive method, including those undergoing a medical abortion who may not be able to access the contraceptive method of their choice at the clinic (i.e. intrauterine contraception).** Some women were reluctant to consider choosing contraception at the time of their abortion. Women who are not ready to make a contraceptive decision at the abortion provider should be sign-posted to good quality local services. There is a need to develop improved pathways between abortion providers, and local contraception services including general practice. We echo our quantitative report here: 'Young women need to be informed of where to go for follow-up services after their abortion, particularly if the abortion clinic is far from their home or if they do not want to return to the clinic for sexual health advice and contraceptive provision. Further, it is important to acknowledge that abortion may be a difficult time for some women who, as a consequence, may not feel ready to undergo contraceptive counselling' (Bury *et al* 2014: 40).
- 3. Abortion providers should advise women to engage productively with their local sexual health services if they experience any difficulty with their selected contraception.** This should include services embedded in general practice.
- 4. Explore ways to bring abortion and contraception services together more effectively, both pre- and post-abortion.** This would not only make it easier for women to be followed-up after their abortion, but could help to de-stigmatise abortion. Additionally, women should not experience unnecessary delays in their referral, and self-referral needs better publicity.
- 5. Improve fertility awareness among young women.** This is in relation to both their general understandings about how their body and cycle work in reproduction, as well as about when EHC might fail (in addition to time limited factors). Some participants became pregnant because they did not understand their pregnancy risk, or else thought that they would still be protected by a recently discontinued method of hormonal contraception. A more nuanced understanding of when they may be more likely to become pregnant could help with contraceptive planning and emergency contraception. Women with improved knowledge might be less inclined to 'wait and see' and to interpret non-pregnancy after risky sex as a sign of invulnerability to pregnancy. These findings also have implications for young women accessing EHC as a reactive method of contraception, since when they are at the peak point of fertility in their cycle, EHC is more likely to fail, and they may not be aware of this. Information about ovulation and fertility should be included in SRE, as well as in all contraceptive information materials.
- 6. Provide an advance supply of EHC for women using user-dependent methods of contraception.** For women who choose a user-dependent method of contraception, it might be beneficial to provide them with an advance supply of EHC. This includes women who are prescribed the pill or condoms from GP/SH services, as well as those who opt for a user dependent method post-abortion. An

advance supply of EHC would enable women to take it shortly after unprotected sex, thus utilising it at its most effective.

7. **Improve awareness among all EHC suppliers of when EHC might fail, and improve provision of the copper IUD as a method of EC.** EHC had failed for a number of our participants which was very distressing for them. Emergency contraception needs improved publicity, access and administration, especially information about when it might fail. There was little awareness among the study group of the IUD as EC. A greater awareness among practitioners of when EHC may fail and how and where the IUD as EC can be accessed would be beneficial in order to sign-post women towards appropriate services. The message that EHC is not fail safe close to ovulation needs to be communicated more effectively. It is evident that many participants had absorbed the message about efficacy and hours post-sex. However, better advice around EHC and efficacy at different points in the cycle would have benefitted participants.
8. **Improve general awareness about the IUD as a method of emergency contraception.** Providers should discuss the emergency IUD with women seeking EHC, especially for those who are close to the EHC time limit or who may have recently ovulated. Information about the IUD should be included in SRE and in all publicity about EC in general. It would be helpful if all guidance about EHC included information about calculating when it might fail, and what to do in these circumstances.
9. **Offer women greater support in their use of the pill if it is their method of choice.** More needs to be done to improve communication about the circumstances when the pill may fail to work, what women can do in regards to emergency contraception and where women can go if they have questions about the pill. A lot of women, particularly young women, still prefer the pill. Greater support could be offered in terms of what to do if a pill is missed, or if the woman is ill while taking it. Bold messages could be added to the packaging. Mobile phones were used in the study population to remind them to take their pill. Perhaps an app which reminds users to take their pill, and also which contains information about what to do if a pill is missed, and where to go for additional support, would be a useful resource.
10. **Improve competency of all providers of contraception through specialist training.** This is a recommendation from the quantitative report that the qualitative study (as indicated in the previous recommendations) clearly supports. It is important that all who provide contraception to women are familiar with the most recent Faculty of Sexual and Reproductive Healthcare (FSRH) guidance on all available methods.
11. **Abortion providers should ensure that women are adequately prepared for side effects following a medical abortion.** Many women described being in a great deal of pain, and of becoming very unwell following the second medical abortion pill. It was especially distressing for women who began vomiting when they were travelling home. Providers need to describe possible side effects, of both methods of abortion, at the first consultation when most women select their method. They should then be sensitive to women's individual needs for pain relief and other support at the time of their abortion.
12. **Combat stigma and acknowledge that abortion is a necessary part of women's reproductive healthcare.** The women's stories were characterised by abortion stigma, which was felt to varying degrees. Providers/policy-makers could talk about improving reproductive control rather than preventing abortion. Others could help establish the *ordinariness* of abortion, so that women who experience an abortion do not feel they have transgressed, or that they are alone. The presence of protestors outside the clinics made participants feel angry and upset. Ways to ensure that women are able to enter clinics without harassment need to be investigated. Finally, Sex and Relationships Education (SRE) needs to include non-judgemental, non-moralistic, discussion of abortion within its remit.
13. **Recognise the important role of informal support networks.** Participants valued knowing the experiences of others, and also having the support of family and friends. A resource which tells the stories of real women's abortion experiences might help women undergoing an abortion to feel less

isolated, and also help prepare them for possible side effects following an abortion. An example resource can be found in [Appendix 1](#).

14. Abortion providers need to remain aware of the importance of sensitive, compassionate and non-judgemental care. Whilst women overwhelmingly described positive experiences at the clinic, it is clear that any negative experiences can cause unnecessary distress. In particular, care needs to be taken with the gestational scan; with the waiting room layout; with client flow arrangements; with women's desire for some privacy; with second pill administration in a medical abortion; and when women feel ill following their abortion. Many participants did not like the communal setting of the abortion clinic waiting room. Perhaps structuring the waiting room to have more privacy would improve client experience. Likewise, thought might be given to allowing companions to stay with women for longer. In addition, perhaps the role of partners/family in supporting women could be considered more sensitively in the context of the clinic and client flow.

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Anywoman

Sharing stories to combat abortion related stigma

This appendix is an example resource intended to help combat abortion related stigma. The title of the resource reflects the statistic that 1 in 3 women will have an abortion in their reproductive lifetime. The stories presented here are compiled by the authors* from interviews given by the qualitative participants in the study to reflect the diversity of different experiences. In any rollout of a future resource it is intended that women provide their own stories with minimal editing. That way, 'anywoman' who has an abortion can share her story to help combat abortion related stigma in her own words. Although the stories here relate to women aged 16-24, we would like the final resource to span the age spectrum and comprise stories from women at all stages of their reproductive life.

Jeanie, 21

I have never really used contraception. When I first started having sex at 15 my partner and I used condoms for the first couple of months but that didn't last long. Generally we relied on withdrawal and that worked so I guess we just thought it was safe. We were together for 5 years until I went to university. I didn't get pregnant the whole time we used withdrawal – although twice when he didn't pull out I went to get the 'morning after pill'. Other than that there weren't any issues. It worked for ages; I actually thought I couldn't get pregnant and that something was wrong with me so I was going to book an appointment to see the doctor to check if everything was all right.

At university I met my current partner; we didn't use any contraception either, but I guess we were just more compatible to conceive because I got pregnant quite quickly. I was very shocked to discover that I was pregnant, and it was a difficult choice to have an abortion. I have always wanted to have children and I'd spent a lot of time thinking that I might never be able to get pregnant. Talking to my sister and friend helped a lot, as well as my partner. He was worried that I might want to keep it and he definitely didn't want to have a baby at that time.

I kind of knew I had to do it because I was studying at university and I had plans for my life that didn't factor having a child at 21, but I was still quite upset after the procedure. It definitely was the right decision for me, but it's just hard to get your head around really. It's quite a big deal.

* with help from Maria Lapavitsas

Monika, 19

My pregnancy did not come at a good time. I know that an unplanned pregnancy rarely comes at a 'good time' but the timing of mine was particularly bad. I had just dropped out of university and my partner's mother had cancer, and this put a massive strain on our relationship. We had only been together for 2 months and I don't think our relationship was very stable.

I have always been very careful with contraception. The first time I had sex I was 15 and I used condoms until I was 17, when I went on the pill. When I got pregnant I was actually taking a break from the pill but my partner and I still always used condoms. Because I have always been so careful and conscientious with contraception, I was really upset about becoming pregnant and having to have an abortion. I did look into adoption at first, but eventually I decided to terminate the pregnancy. I felt quite alone and like I couldn't talk to my family because I thought they were angry with me for dropping out of university. In addition my partner wasn't very supportive. I went to the clinic alone and opted to have a medical abortion. I felt very emotionally drained by the whole experience but I found reading about other women's experiences helpful. Abortion is a very controversial topic and a lot of people have very strong opinions about it. However, I feel that it isn't something you can understand unless you have been through it.

Carly, 24

When I found out I was pregnant the first time, I felt like a bit of a slapper. I mean it's not difficult. Contraception is free. It's not difficult to come by; there are loads of places where you can get contraception. I used to judge other girls who would get pregnant and have babies at 18, and then there I was, in the same boat. I had been on the pill since I was really young because of problems with my periods but for about six months before I got pregnant the first time I went through a bit of a naughty, rebellious phase and I just stopped taking it. That was why I got pregnant. The guy I was involved with at the time was really nasty about the whole situation he just turned up at my door with £500 and said 'Just go private. Get it sorted.' So I decided to terminate. It wasn't just because of him, it was definitely my own decision; I knew I was too young.

After this I got a new boyfriend who I was with for the best part of 5 years. We decided to have a child, so I got pregnant and kept the baby. I was on lots of different types of the pill for most of this time; I had to keep changing because they kept disagreeing with me. After my relationship ended I stopped taking anything because I wasn't thinking about being sexually active with anyone. I had a reconciliation with my ex and that was how I got pregnant again. Deciding to have an abortion was easier the second time, so I booked in for one at the clinic. However about five days before I went to the clinic I started bleeding so by the time I got there they actually said I'd miscarried.

Looking back I can see that the abortions were an easy choice to make, it was just a difficult time. I feel that I have learnt my lesson and am so much more careful about using contraception now. In the end, despite feeling angry with myself for getting pregnant, I knew that the choice to have an abortion was mine to make. I feel like the choice was the right one for myself and for my child.

Lilly, 18*

Before I had my abortion, I'd always thought it was very hard to get pregnant. You hear about couples struggling to have a baby all the time – I suppose I thought that it wouldn't happen to me, and I just wouldn't become pregnant. My boyfriend is away at university and I don't get to see him very often – probably only every other weekend. Because I don't see him very often and we don't have sex very regularly, sometimes taking my pill isn't at the forefront of my mind – so I forget it. There's no real urgency to take it every day. That weekend when I did get pregnant, was when I went to visit my boyfriend. I actually realised on the train that I'd forgotten my pack of pills. I'd been in a bit of a rush that morning to pack my bag and get the train and I must have just forgotten to pick them up.

That night, on the Saturday, we went out with friends and had a great time dancing at the union bar. It must have been about 1 a.m. when we got back to his house, and although we weren't all that drunk, we got carried away. I'd asked him to pull out before he came, but obviously that didn't work. The next morning I sort-of put it out of my mind. I briefly thought about getting the 'morning after' pill, but I didn't really know where to go to get it from, and whether or not I would have to pay for it. We also had plans to meet his friends for lunch, so I didn't really think much more about it. I wasn't very worried, because I'd missed pills before and not become pregnant. I thought maybe I was infertile – well not infertile, but I thought perhaps it would be difficult for me to have children, because my periods have always been quite irregular. When I got home, I chatted to my friend about my weekend, and she told me not to worry, because she had read on the Internet that the pill stays in your system for months after you stop taking it. So I didn't really think about it again. I'd only missed 3 days, so I thought that I would be covered.

After a few weeks, my boobs started to feel really painful, and I thought that maybe I was due on. To be honest, I never really know exactly when I'm due, because my periods are so irregular. I waited a couple more weeks, but my period never really came. I'd also been feeling a bit sick too, and it was my work colleague, actually, who suggested I should do a test. I didn't really take it that seriously, and bought a cheap pregnancy test from the Pound Shop on my way home. When both lines came up, I freaked out. I decided to buy another one the next day from Boots – one of those 'Clearblue' ones – and again, two lines. I think I cried on the bathroom floor an hour. I didn't want this to be happening to me. I live at home at the moment, and when my mum got home from work, I told her that I was pregnant. She was shocked, because she knew I was on the pill, but she was also supportive, and told me that she would be there for me, no matter what my decision was. She sat with me while I called my boyfriend. When he answered the phone I just burst in to tears and blurted it out. He didn't really know what to say to me. I think it caught him off-guard too. We didn't really discuss it in too much detail over the phone. We decided to give ourselves a few days for it to sink in before talking again. He was due to visit me at the weekend anyway, so we decided to discuss it face-to-face when he arrived.

He got to my house on the Saturday morning, mum had gone out. We both sat there on the sofa not saying anything, and not knowing what to do. Eventually he said that he wanted me to keep it. He's a bit older than me – he's a mature student – and perhaps he felt nearer the

* This longer narrative is compiled from a number of participant's different stories. Plans are in place to produce a short animation based on this story.

age when you settle down and have kids. But my life really wasn't at that point. I was still at home living with mum. I wanted to work, I wanted to have a career. Although I'd never really agreed with abortion, I just didn't feel ready to have a baby. Also, my relationship with my boyfriend got more difficult once he had gone to university to study. In all honesty, we were arguing a lot, and he still has another 2 years left of his degree. I didn't want him to drop out to look after me, and I also didn't want to be a single mum. My parents divorced when I was little, and things had been hard. I didn't want that life for me, or for my child. I would have struggled on my own.

I told him that I didn't feel ready to have a baby – that we didn't have anywhere to live or any way to support a child. I mean, having a baby is expensive. It would completely change our future plans. He said that he understood, and he would support me throughout. But to be honest, I just wanted my mum to be there for me. It would have been too hard to go to the clinic with him, knowing full well that he really wanted me to keep it. It would have made it harder for me – I knew this was a decision that I had to make for myself. Once I'd made up my mind it was easier. I felt relieved that I was going to sort this situation out. I booked an emergency appointment with my GP for early the following week. He gave me the phone number for Marie Stopes, and I called them up when I got home. I had the option of having a consultation over the telephone, or one face-to-face. I opted to have it over the phone. The lady was really nice. I'd half expected her to tell me off or something. We went through the consultation and then she made me an appointment for the following week. I couldn't believe how easy it was, actually. After all the stress of finding out and having to make a decision, it was quite straightforward from then on.

Looking back on my decision now, it was absolutely the right one for me. I'm still with my boyfriend, and we're trying to work things out, but I'm a lot more careful taking my pill. At the clinic, after my procedure, they did offer me different types of contraception. I could have had the implant, injection or a coil fitted. However, I was happy using the pill. I feel as though I know what went wrong, and I won't make that same mistake twice. Not to say that the whole experience wasn't difficult – it's changed me as a person. At first I felt very relieved, but in the days afterwards I was a bit tearful. I think I was mourning my loss and mourning my mistake. It was hard because I didn't believe in abortion before, but I now I think that you can't really judge someone until you have been in that situation yourself. I was offered counselling at Marie Stopes, but I didn't feel that I needed it. Perhaps one day I will, but at the moment I feel fine and I'm ready to move forward with my life. I suppose realising what I didn't want has helped me to focus on what I do want from life. At the moment that is to concentrate on my career and to work towards saving up for a place of my own, so that my boyfriend and I can move in together, once he finishes his studies. I hope that the next time I fall pregnant, it will be a wanted baby, and we'll be in the situation to support it and love it in the way I always imagined. You know, '2.4 children', and all that. I just wasn't ready for a baby at 18. I don't think anyone should judge me badly for that.

Elaine, 20

This was my second abortion. When I was 17, my periods stopped completely because I had an eating disorder, so I didn't even think that I'd be able to get pregnant. Later, when my periods started again I carried on with my pill. I don't know really how I became pregnant – it must have just been this one time but he never fully did anything inside me so I didn't think that you could get pregnant from that. Well, I knew you could, but I thought that the chances were so slim that it wouldn't matter if we just risked it.

I was shocked both times when I found out because I thought it was really hard to get pregnant. I thought it was really, really hard. With the amount of people that struggle to get pregnant I felt a bit selfish when I did get pregnant and considered having an abortion. I was very young so that first abortion was very scary for me; also it was difficult because I was in a very controlling relationship. My partner used to stop me going out and stopped me from drinking and things like that. He made me promise to have an abortion and then made me feel guilty for considering keeping it. In hindsight, I can see now that this was not the kind of relationship a child should be brought into, but after my abortion I felt bad. I woke up from the anaesthetic crying.

Really, I just wasn't ready, physically or mentally for what was going to happen. I'd had it all explained to me but I just didn't know what to expect and I felt really guilty afterwards. I wasn't ready to have a child but that doesn't mean that I didn't feel guilty for getting pregnant. I got counselling afterwards to help me deal with my emotions.

This time when I became pregnant I found the experience easier because I'd been through it before. Even though I still felt quite emotionally raw after the surgery, I absolutely knew having an abortion was the right decision to make.

Annabel, 19

I ran out of the pill and couldn't get an appointment at the doctors' surgery, that's when I became pregnant. Online, I had read that the pill stays in your system for a while after you stop taking it so I thought I would be fine not to take it for a bit – but obviously, that was wrong. My partner never found out I got pregnant because I know he would have wanted me to keep it and I didn't want to cause an argument or upset him. I knew what I had to do. I was still in full time education and felt like I wasn't ready to have a child. It was an unfortunate situation and I did have moments before I actually got it done where I would lie in bed and feel quite sad and think 'there's actually a child inside me.' Moments like that really upset me. After the abortion I didn't leave the clinic with contraception and I was later offered the implant at my doctor's but I changed my mind. I want to start the pill but haven't got around to it yet so I'm just using condoms at the minute.

When I look back I guess it is always going to be a part of my life and something I had to go through – but life happens. I mean abortion, it's an upsetting thing, it's a traumatic thing, and it's a controversial thing. But at the same time, it's there for a reason.

Lexi, 24*

I never wanted to be pregnant. I have had three abortions. It sounds really bad doesn't it? But I don't think that I can really blame myself. Each time I've been using contraception – it just hasn't worked for me. I've always used the mini-pill, but I work hard – I do shift work, and sometimes it's difficult to remember to take it at the same time each day. Occasionally I will use condoms, if I think I've been particularly late with it. With my most recent abortion, I took the morning-after pill because I knew I might be at risk, but even that didn't work for me, and I ended up pregnant again. I guess contraception just doesn't really work very well with my body.

My first abortion was when I was 16. I wasn't terribly responsible at that age, and I found the experience quite distressing. I had a surgical abortion in hospital. I think it was quite late, because I didn't want to know that I was pregnant, so I just ignored it. However, each time I've been pregnant it's made me ill, like, really, really sick, so eventually my Mum knew something was up. When I had my first abortion, I remember feeling humiliated. It wasn't a nice experience, and I felt like I was treated as just another stupid little girl. It really upset me for a long time.

When I fell pregnant a second time I was 19. Again, I was really upset – especially given my first experience. However, I wasn't in a very stable relationship – we were very 'on and off'. I didn't have much money, and having a baby just wasn't a possibility. For my second abortion, my GP referred me to Marie Stopes, and I had the tablets. I don't know if everyone has the same experience, but for me it was a bad experience. You sit in a room full of people, and they are all going through the same experience as you – all sitting there waiting for the tablets to dissolve. There were young girls in there crying. I didn't feel very comfortable. When my boyfriend picked me up from the clinic, he was shocked by how quickly I was affected after I took the second tablet. On the way home in the car, I was feeling really sick, and my stomach was making really tight cramps. When I got home, I ran inside to the toilet, and I was bleeding really heavily. That night I didn't sleep very much at all, because I was in so much pain. I didn't feel very well for quite a few days. I just wanted to curl up in bed. I think I probably bled for 2 weeks continuously. I didn't realise it would be such a long experience.

About a year ago, I met my current partner, and we've been living together now for about six months. When I found out I was pregnant this time – the third time, it was a harder decision to make. This time I was 24 – I guess I'm old enough to have a child, but I still don't feel ready for that yet. There are things I want to do first – my partner and I want to see the world and go travelling. That just wouldn't be possible with a baby. I referred myself to Marie Stopes this time. Once I had made the decision, it wasn't so hard to go through as previously. I guess I knew what to expect. This time I opted for a surgical abortion, because I didn't want to have to go through all that bleeding again.

I haven't really reflected back on my abortion this time. The first two times, I was really upset afterwards, but this time I wasn't. It's, like, I just went through the motions and am now getting on with my life and my plans. Having a child isn't really on my agenda at the moment. We're saving up for travelling and I'm looking forward, not back. The nurse did suggest that I have an implant at the clinic, but I don't really want to change my contraceptive. I've been

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using the pill for years, and I'm happy with it as a method. I know it's failed me on a few occasions, but no contraceptive method is 100%, and it has worked for me for a while – there has been some time between my abortions. I think I'm probably just really fertile. I like the control the pill gives me over my periods. I like to know when they are coming, and I like to be able to skip one – it's just convenient and gives me control over my body.

Evelyn, 21

I went on the pill when I was 13 because I had really bad periods, just absolutely horrible, so I went to the doctor and they said that the pill would be a good thing for me. I was on it for about 7 years, which seems a really long time.

I got my first long term boyfriend at 14, we were together for 5 years and I just carried on taking the pill whilst we were dating. I continued with it after we broke up. I'm in a different relationship now and about 6 months ago I just decided that 'I've been on this pill too long, constantly taking it every day. I don't want to have drugs in my body.' My body felt like it needed a break from the hormones so I stopped taking it. My partner and I agreed to use condoms but one split and I left it too late to get the 'morning after pill' because we were away camping at the time so there was nothing I could do about it. My period was due around about that time so I thought I would be okay, but I guess I was unlucky and I got pregnant.

I was in my last year at university so I knew straight away that I couldn't keep it. With the massive debt from student loans I could never afford a baby as well, not for a few years at least. When I have a baby I want to be able to give it everything. Having a baby at this age does not coincide with my plans for the future. I don't know if I'm secure with my new partner and I feel like I'm the one doing things like working and going to university so it's just really hard. My mum, sister, aunty and boyfriend all supported my decision and I am happy with the choice I made. I expected to feel upset but I felt relieved instead. It just wasn't the right place or the right time. That's actually how I put my mind to it.

Daisy, 22*

I used to think that I couldn't get pregnant, because I have always had irregular periods. I really used to struggle at school with them – they were unpredictable, and when they did come they would be heavy and painful. I can't remember exactly when I started taking the pill, but I was probably about 15, and at first it was purely to control my periods on the advice of my doctor – sex came a bit later. When I was 16, I met my first proper boyfriend at college. We were together for two years, and during that time I took the pill without any problems.

A couple of months after we split up, I met my ex – who is also my daughter's dad. When I started a relationship with him, I was still taking the pill. I'm not really sure what happened when I got pregnant that first time. I always thought that my chances of conceiving naturally were probably pretty low, so when I found out I was pregnant, I was really happy. I know I was only 19 years old, but I had it in my mind that perhaps I would never be able to have a baby, so the decision to keep her was a really easy one to make – I felt it was my only chance to be a mother. My partner, however, was not so keen. He really didn't want to be a father, and he left me before she was born. I was 19, and a single mother. It was hard, and it was hard to make ends meet and put food on the table. I really struggled during her first few months. I had limited contact with her father, and although I wouldn't change her at all for the world, it was tough.

My daughter was about 18 months old when I met my current partner. I returned to using the pill, but this time I found it more difficult to remember to take it. I love my daughter to bits, but she was a very demanding baby, and sometimes I got distracted from myself. I knew at that point I didn't want another child – I wanted to wait for a few years until she'd grown up a little bit and was in school, so I decided to look into getting the coil. My friend had just had one fitted, and she really raved about how great it was. I wanted the same one – the copper one without hormones. I didn't like the idea of not having a period – I wanted to see it every month, so that I could be sure that I'm not pregnant.

I went to the GP for an appointment, but it took a really long time to arrange. First of all I had to have an appointment with the nurse to get swabs done, and then I had to go back for an appointment with the doctor to have the coil fitted. It's awkward because the surgery only offers a few appointments for coil fittings a week, and only one GP fits them. At first she was on holiday, so I had to wait and book an appointment for two weeks later, when she was back. The day before I was due to have it fitted, the surgery called and cancelled my appointment, because the GP was sick. It was rearranged for the following week. When I finally went to my appointment, the GP did a pregnancy test, and to my surprise I found out I was pregnant again. I was in complete disbelief. I'm really not sure how it happened to me again. I thought I was being responsible in having a coil fitted. I was just unlucky I guess – I must have missed a pill or taken it late, but I don't really remember. All I do remember is feeling really disappointed. The bus ride home was a bit of a blur. I was in shock. My partner knew something was wrong when he came home from work that evening. I didn't cry, I think I was more angry with myself and my situation than anything else.

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That night we spoke for a long, long, time and tried to work out what to do, and how much money we had. It was a hard decision to make, and one we didn't find easy. In the end we both decided that it wasn't the best time to have another child. He also has a young child from a previous relationship who stays with us at weekends, and having three children under 5 to look after just wasn't a realistic option. The next week I went back to my GP, and they referred me to Marie Stopes.

On the day of my abortion, my partner came with me to the clinic. I didn't really know what to expect, but the staff were all really nice. I have to say that I thought I might feel judged, but it really wasn't like that. If anything, I felt they took the time to listen to me. The first nurse I spoke to helped me to decide which method of abortion to have. You can have two types – one in which you take two pills which cause a miscarriage, or a surgical abortion. I decided on having a surgical abortion instead of taking tablets, because it was over and done with quicker, and I couldn't risk being ill for hours, when I had my daughter to look after. She also talked to me about contraception, and they said that they could fit the coil at the same time as my abortion, so that's what I opted for. It was important to me to have the coil fitted and to make sure that I don't get pregnant again, before we can afford and care for another baby. I know I made the right decision, but I don't deny that it was hard. For me personally, my main reason was that I didn't want my daughter to suffer because of my mistake. Financially, it's hard and emotionally too – it's tough giving her all the attention she needs. I just didn't want her quality of life to be affected.

Brooke, 17

I got pregnant due to a split condom. It seems so strange that such a small thing can lead to such a big decision. I started having sex at 16, my then partner and I used condoms and I was on the pill to be completely safe. The pill really didn't agree with me so I stopped it, but then starting dating another guy.

This was the guy who got me pregnant. He basically told me 'get rid of it' because he was leaving to go back to the army. He didn't want anything to do with me; this left me in a very vulnerable position because I was so young. I didn't want to raise a child in those circumstances. The fact that he was going to be away and wasn't going to be there to support me made me nervous about having his child. I mean he didn't want anything to do with me so who's to say he would want something to do with our child? I've seen people brought up in that scenario, where their dad isn't involved, and it's just horrible. I didn't think I was old enough and mature enough to be a mother yet.

Also, I wanted to further my career as a secretary, which wouldn't have been possible with a young child. I had such strong support from my family, and ultimately I think I made the right decision. The people at the clinic were lovely, and even though I felt very drained afterwards I was glad that I went through with it.

Erin, 19

I started having sex at 13 and went on the pill pretty much straight away. I had a number of short, casual relationships until I was about 16 when I met my first long-term boyfriend. Because it was quite a serious relationship I decided to have the implant put in and I kept it for 3 years. Then I had it removed. I had to have treatment for ovarian cysts and was advised not to get new contraception until after my next period, but in the end I didn't seek any contraception at all. I think my current partner and I got a little bit stupid and careless. I fell pregnant at 18 and kept the baby. After the birth of my daughter, I suffered from post-natal depression and it took me a long time to bond with her. Following her birth I started taking the pill again but on one occasion that I had sex, I forgot to take it on time and so took it later on in the evening instead. I knew I was at risk and I really didn't want to become pregnant again so I went and took the 'morning after pill' just in case. I hadn't had a period since I'd given birth, so as a precaution I did six pregnancy tests. They were all negative. I went to the doctor and the doctor also did a test, which was positive.

When I found out, I was so upset – I felt like I had taken every precaution I possibly could and yet I was pregnant again for the sake of a few hours when I forgot to take my pill. Considering the post-natal depression I'd had with my first pregnancy, I really hadn't wanted to become pregnant again. Coping with two children under the age of one was just not an option, so I decided to terminate the pregnancy. After the procedure I felt fine. I kept expecting to feel sad or guilty but those feelings just never came. I feel I made the right decision for me at that stage in my life. I had just started to form a bond with my daughter, and that was the most important thing to me.

Maisie, 22

Last year I was actually trying to get pregnant. I started having sex when I was 20 and I tried a number of different pills but they just didn't agree with me, so I was using condoms as contraception. Obviously my partner and I stopped using them when we were trying to conceive. When I got pregnant, it turned out to be an ectopic pregnancy, which was just a horrific experience, and after going to A&E I had to have one of my fallopian tubes removed. I was so upset and I felt really scared about whether I would be able to get pregnant in the future.

After the surgery I didn't have a period; the doctor told me I wasn't ovulating so then I didn't use contraception. I don't really see how I got pregnant. When I found out I was actually back in education, and not working, and I felt like the timing wasn't right to have a baby. I remember my mum really wanted me to keep it. After the abortion it was like she hurt more than me. That's how I felt. In the end, she agreed with me that it was the right decision.

Cheryl, 23

I became sexually active at 17, and for a few years, used condoms and the pill. I also had the implant for about 6 months but I went back on the pill because I hated the irregular bleeding that I had with it.

I think I became pregnant because I was ill and the pill failed. Before I got pregnant I didn't really believe in abortion, but getting pregnant is easy - I just didn't realise how easily it could happen.

I had counselling before my consultation and that really helped, just talking it through with someone. I decided to have an abortion because I was not financially stable and I still felt too young to have a baby. Now, I guess I've just completely blocked it out, I can't think of it in terms of something real that happened to me. I'm just getting on with my life and have put it behind me. I'm being very careful with my contraception now, I hope that the next time I find out I'm pregnant it will be a blessing.

Sienna, 22*

When I found out I was pregnant, it was very clear to me that I was going to have an abortion. I didn't tell anyone about my decision. I didn't feel I needed to. I became pregnant when I bumped into an ex-boyfriend, just randomly, at an exhibition we both attended. He had been a childhood friend who lived on my street, and I'd lost my virginity to him when I was 16. We dated for a little while after that, but we lost contact with each other when I went away to university.

We arranged to meet up for a drink, as friends. I hadn't been expecting to have sex that evening. I'd been having a hard time recently. My mother wasn't very well, and I'd been caring for her. When I met him, it was fun – we were laughing and joking and I didn't really want to go home. I suppose I just wanted to do something for myself. To have some focus on me. It was nice to have someone's attention, and I've always enjoyed sex and been a sexual person. So one thing led to another and funnily enough, he asked me if I was on the pill. I don't know why, but I just told him it would be okay. The truth was, I wasn't using anything. I'd tried the implant when I was younger, but I just couldn't get on with it. It didn't agree with my body. I had persistent bleeding while I was using it, and it became unmanageable. I had to wear protection every day. It was expensive and it was uncomfortable. You just don't feel clean when you are constantly bleeding. I didn't use anything after that, because I just wanted my body to return to normal.

After we'd had sex, for the next couple of days I did think about the risk I'd taken. I thought about getting the 'morning after pill', but I don't know, I just didn't get round to it. I'm a busy person, and have quite a full-on job in addition to caring for my mother. By the time it got

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to 72 hours I knew I had missed the window for getting emergency contraception, so I just decided to wait and see. At that point I thought there was nothing more I could do. I didn't know that I could have had a coil fitted to prevent pregnancy. I only found this out later. In fact, after my abortion I chose to have a copper coil fitted, because I didn't want to be in the same situation again, and also because it was hormone free – I'm funny about messing with my body these days, I'd rather just be natural. When I found out that I could have had it fitted beforehand, I was really quite upset with myself. I think that it should be publicised more. I'm an intelligent woman, and I didn't know about it. It could have prevented me from having to go through an abortion.

Although probably I'm at an age where I could have supported a baby, and could have been a single mother, that wasn't really the life I envisaged for myself. My career is going well, but I'm not there yet. I really want to make a difference and have some sort of impact. I want to make a name for myself, and having a baby just didn't factor into my 5 or even 10 year plan! I didn't tell anyone about my abortion at the time. Not even my friends. I didn't see the point in telling the guy, to be honest. What difference would it make? I absolutely knew I wasn't going to keep it, so telling him would just have been pointless. He didn't need to know anything about that.

When my period was late, I peed on a stick, found out I was pregnant and the next day made an appointment with my GP. It was a bit of a nightmare actually, she said she didn't deal with abortions because of her religious views, and referred me to another GP. I'd felt quite judged by her and had to wait around to see the second GP, who gave me the number for Marie Stopes. I left the GPs' and rang Marie Stopes straightaway, on the street. They arranged the telephone consultation for later that day, and gave me an appointment for the following Monday.

I arrived by taxi, and outside the clinic there were all these protestors. It really pissed me off. Who do they think they are to be judging what I do with my body? It didn't make me feel bad. It just made me feel angry. They had these graphic pictures – for any other medical procedure, you aren't faced with images of your operation are you? They were clearly just trying to upset women and make them feel bad. Although I wanted to confront them, I walked straight past without even acknowledging them. I was just focussed on getting to my appointment.

After the abortion, I just felt relieved. I was waiting for the emotions to come, for me to feel bad, but it just never happened. I guess maybe I feel kind-of guilty for not feeling guilty – if that makes sense? I am absolutely certain that I made the right decision. I didn't want to be a mother, and I didn't want to bring an unwanted child into the world.

Since my abortion, my friend found out she was actually pregnant, and had a termination. I later told her about my experience. I think it helped her – I felt as though I could support her through the process. She told me that her mum had also had a termination when she was younger. It's really surprising how many women do have abortions, and yet don't talk about it. It's like one of those 'hush-hush' things. I don't know if its shame, or society, or whatever, that makes us think this way, but I do think it would be so much easier for women if we could just speak about it. It's even difficult to talk about it among friends – we talk about our experiences of contraception, so why not talk about this? I was really glad the option was there for me, and I appreciate the control it gave me over my body, and over my life.

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